

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film G381 10/18/66 mh

13296

CERTIFICATE OF DEATH

13290

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Pa. Maryland</b> b. COUNTY <b>Franklin Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>3 Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Jackson Conv. Home</b>		e. STREET ADDRESS <b>37 N. Main St. Jackson Conv. Home</b>	
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>F.</b> Last <b>Agnew</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>27</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 4, 1878</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Merchn.</b>	9. AGE (In years last birthday) <b>87 yrs.</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Mercersburg, Pa., R.D.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Agnew</b>		14. MOTHER'S MAIDEN NAME <b>Harriet Eliza Rhea</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>179-07-3451A</b>	
17. INFORMANT <b>James E. Agnew</b>		Address <b>Littleton, Colo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5271 Emphysema</b> DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 19 63</b> , to <b>Sept. 19 66</b> , that (I) (we) last saw the deceased alive on <b>Sept. 16 19 66</b> , and that death occurred at <b>10 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Howard N. Weeks</b>		22b. DATE SIGNED <b>9/29/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M.D.</b>		22d. ADDRESS <b>580 Northern Avenue Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9/30/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Mercersburg, Pa.</b>
24. FUNERAL DIRECTOR <b>J. M. Geringer</b>		25a. REC'D BY REGISTRAR <b>OCT 4 1966</b>	
ADDRESS <b>Mercersburg, Pa.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1933

1933

James M. Smith

## CERTIFICATE OF DEATH

13297

13291

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN Tb <u>14 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>554 West Church St</u>				d. STREET ADDRESS <u>554 West Church St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>LEE</u> Last <u>ANDERSON</u>				4. DATE OF DEATH Month <u>September</u> Day <u>27</u> Year <u>1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31 1870</u>		9. AGE (In years last birthday) yrs. <u>96</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown Wash Con Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John M. Stouffer</u>				14. MOTHER'S MAIDEN NAME <u>Isabelle Mace</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Gladys Gower 554 W. Church St</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerosis</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coarctation</u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Dehydration</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 24</u> , 19 <u>66</u> , to <u>Sept 26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept 26</u> , 19 <u>66</u> , and that death occurred at <u>4:00 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>C. M. Mandell</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/27/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ANDREW M. MANDELL, M.D.</u>				22d. ADDRESS <u>119 E. ANTIETAM ST., HAGERSTOWN, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/29/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash C. Md.</u>	
24. FUNERAL DIRECTOR <u>Hagerstown Md</u> ADDRESS <u>Andrew K. Coffman Funeral Home Inc</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1951

1951

1951

## CERTIFICATE OF DEATH

13292

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Agrestown</u>		c. LENGTH OF STAY IN lb. <u>8 hrs 15 m.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Myersville</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Co. Hospital</u>		d. STREET ADDRESS <u>1002</u>	
3. NAME OF DECEASED (Type or print) <u>BETTY JANE BAKER</u>		4. DATE OF DEATH <u>September 26 1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 25, 1966</u>
9. AGE (If years last birthday) <u>8</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>8 15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wash Co, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CONRAD E. BAKER</u>		14. MOTHER'S MAIDEN NAME <u>MARY JANE HARR</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>CONRAD E. BAKER</u>		Address <u>Myersville, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>776X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 Hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5pm 9-25, 1966</u> , to <u>10:46 AM, 1966</u> , that (H) (we) last saw the deceased alive on <u>9-25 1966</u> , and that death occurred at <u>12:30 A.M.</u> from causes on and on the date stated above.			
22a. SIGNATURE <u>Charles F. Hess</u>		22b. DATE SIGNED <u>9-26-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles F. Hess, M.D.</u>		22d. ADDRESS <u>Smithsburg, Maryland 21783</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Sept. 27, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HARMONY</u>	23d. LOCATION (City or Town) (County) (State) <u>Myersville Fred. Md</u>
24. FUNERAL DIRECTOR <u>Paul J. Bate</u>		25a. REC'D BY REGISTRAR <u>SEP 27 1966</u>	
ADDRESS <u>Myersville Md</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Jones</u>	

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DEPARTMENT OF THE ARMY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

13299

13293

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>30 YR S.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>39 E. WASHINGTON ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ADA</b> Last <b>BAUMGARDNER</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>24</b> Year <b>1966</b>					
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/6/1886</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED SCHOOL TEACHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PUBLIC SCHOOL</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>DAVID L. WOLFINGER</b>			14. MOTHER'S MAIDEN NAME <b>MARTHA A. STINE</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. VIRGINIA MYERS</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis - cachexia</b> 332X DUE TO (b) <b>Arteriosclerotic vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>yrs</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. - p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>	20f. (City or town) <b>-</b> (County) <b>-</b> (State) <b>-</b>				
21. I certify that (I) (this hospital) attended the deceased from <b>Aug</b> , 1961, to <b>Sept. 24</b> , 1966, that (I) (we) last saw the deceased alive on <b>Sept. 24</b> 1966, and that death occurred at <b>P. M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Harold R. Tritch, Jr.</i>			22b. DATE SIGNED <b>9-26-66</b>				
22c. PHYSICIAN'S NAME (Type) <b>Dr. Harold R. Tritch, Jr M.D.</b>			22d. ADDRESS <b>302 N. Potomac Street Hagerstown, Md</b>				
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>	23b. DATE THEREOF <b>9/27/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>	23d. LOCATION (City, town or county) <b>HAGERSTOWN</b> (State) <b>MD.</b>				
24. FUNERAL DIRECTOR <b>W. J. Norment, Hagerstown, Md</b>			25a. REC'D BY REGISTRAR <b>SEP 23 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

13300

13294

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MARYLAND</b> COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>1 MON</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Western Md. State Hosp</b>				d. STREET ADDRESS <b>Cumberland St.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ann Elizabeth Boyd</b>				4. DATE OF DEATH Month Day Year <b>Sept 25 1966</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>Wh</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-28-79</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home duties</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>DANIEL G. BOYD</b>				14. MOTHER'S MAIDEN NAME <b>LUCY V. BOYD</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>216-46-488</b>			
17. INFORMANT <b>George Boyd</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive failure</b> DUE TO <b>Coronary Sclerosis</b> DUE TO <b>Arteriosclerosis, generalized</b>			
19. INTERVAL BETWEEN ONSET AND DEATH <b>10yrs</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8-22-66</b> to <b>9-25-66</b> , that (I) (we) last saw the deceased alive on <b>9-25-66</b> , and that death occurred at <b>10PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Edwin G. Riley</b>				22b. DATE SIGNED <b>9-26-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Edwin G. Riley</b>				22d. ADDRESS <b>W. Md. State Hosp, Hagerstown Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/28/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Margaret Rowland</b>				25a. REC'D BY REGISTRAR <b>OCT 5 1966</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

13300

WASHINGTON

HAGERSTOWN

Western Md. State Hosp

Ann

Wm

F

HOUSEKEEPER

DANIEL G

BOYD

No

26-41-43

Candid

Acute congestive failure

Coronary sclerosis

Arteriosclerosis, generalized

8-22-66

9-22-66

Edwin G. Riley

W. Md. State Hosp/Hagerstown

Resident

DET

Chief Clerk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove the bottom papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
TSM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13295

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>SHENANDOAH</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodstock</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hawthorn Church Home</u>		d. STREET ADDRESS <u>CHURCH STREET</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Rush</u> Last <u>Boyer</u>		4. DATE OF DEATH Month <u>9</u> Day <u>28</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-3-1885</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u> Hours <u>15</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>15</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>	
11. BIRTHPLACE (State or foreign country) <u>Woodstock, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles F. Rush</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Alice Hattel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>225-54-7381</u>	
17. INFORMANT <u>Mark G. Wagner</u>		Address <u>2750 Va Ave Williamsport, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> 40X DUE TO (b) <u>Hypertensive C. v. disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>8 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>Jan 2-9</u> 19 <u>66</u> to <u>Sept 28</u> 19 <u>66</u> . that (I) (we) last saw the deceased alive on <u>9-27</u> 19 <u>66</u> and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert P. Coyne</u> M.D.		22b. DATE SIGNED <u>9-29-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert P. Conner</u>		22d. ADDRESS <u>137 W. Wash Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE THEREOF <u>9/28/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MASSANUTTEN CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>Woodstock VA.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>CHARLES M. ROUZER</u>		25a. REC'D BY REGISTRAR <u>OCT 2 1966</u>	
ADDRESS <u>HAGERSTOWN, MARYLAND</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



## CERTIFICATE OF DEATH

Reg. Dist. No. **13296**

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <b>Maryland</b> <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Myersville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>Lloyd R. Brandenburg</b>		4. DATE OF DEATH Month <b>September</b> Day <b>2</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 3, 1895</b>
9. AGE (In years last birthday) <b>71</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Co. Roads</b>	
11. BIRTHPLACE (State or foreign country) <b>Wolfsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry L. Brandenburg</b>		14. MOTHER'S MAIDEN NAME <b>Louise Grossnickle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-01-3992</b>	
17. INFORMANT <b>Mrs Elizabeth Brandenburg</b>		Address <b>Myersville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Lymphatic leukemia</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>6 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7-31-1959</b> , to <b>9-2-1966</b> , that I last saw the deceased alive on <b>9-1-1966</b> , and that death occurred at <b>1:20 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Charles F. Hess</b> <b>9-2-66</b>			
ACTUAL SIGNATURE <b>Charles F. Hess</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Charles F. Hess</b> <b>Smithburg, Maryland</b>			
22a. BURIAL, CREMATION, REMAINS	22b. DATE THEREOF <b>Sept. 4, 1966</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Grossnickle's</b>	22d. LOCATION (City, town, or county) (State) <b>Myersville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul F. Bittle</b>		ADDRESS <b>Myersville, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>SEP 6 1966</b>
		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





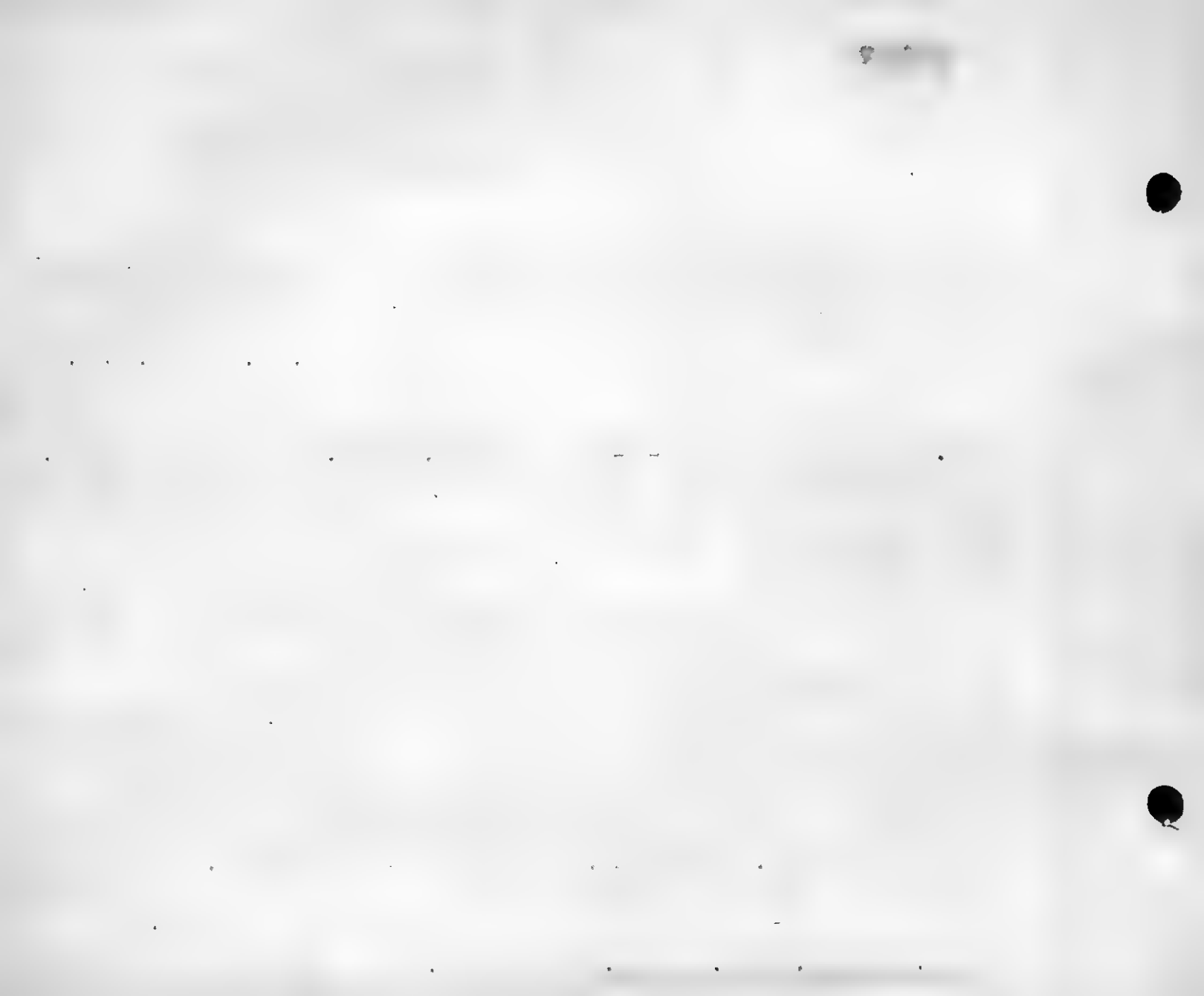
CERTIFICATE OF DEATH

13294

1 PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Funkstown</b> c. LENGTH OF STAY IN 1b <b>16 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Funkstown</b> d. STREET ADDRESS <b>Box 173</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>William John Brittain</b>		4. DATE OF DEATH Month Day Year <b>September 13, 1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 30, 1905</b>
9 AGE (In years last birthday) <b>61 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Taylor &amp; Musician</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>		11 BIRTHPLACE (County & State, or foreign country) <b>Tresco Hazelton. Pa.</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Edward Brittain</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth Gallop</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>	
16 SOCIAL SECURITY NO <b>207-10-2392</b>		17 INFORMANT <b>Carrie M. Nelson, Box 173, Funkstown, Md.</b>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVA. BETWEEN ONSET AND DEATH <b>3 1/2 - 3 yrs</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 31</b> , 19 <b>63</b> , to <b>Sept 13, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 10</b> , 19 <b>66</b> , and that death occurred at <b>11:30 AM</b> , from causes and on the date stated above.			
22a SIGNATURE <b>Philip J. Hirshman</b>		22b DATE SIGNED <b>9/14/66</b>	
22c PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>		22d ADDRESS <b>159 W. Washington St., Hagerstown, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-16-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>	
24 FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		25a REC'D BY REGISTRAR <b>SEP 16 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil, item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
3500 4-64

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>45 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1020 Lincoln St.</u>				e. STREET ADDRESS <u>1020 Lincoln St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Faye</u> Middle <u>Elizabeth</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>September</u> Day <u>12</u> Year <u>1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 5, 1900</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Gapland, Md.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Elmer Lee Gordon</u>				
14. MOTHER'S MAIDEN NAME <u>Laura Lavaia Boyer</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				
16. SOCIAL SECURITY NO. <u>214-09-6402D</u>			17. INFORMANT Address <u>Hagerstown, Md.</u> <u>Mr. Daniel H. Brown 1016 Lincoln St.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 7201 } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic coronary artery disease</u> DUE TO (c) <u>years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Howard N. Weeks</u>		M.D. <u>Howard N. Weeks, M.D.</u>		22. DATE SIGNED <u>9/13/66</u>			
EXAMINER'S NAME (Type)		Address (Street, city, town, or county) <u>580 Northern Ave. Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/15/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>				
24. FUNERAL DIRECTOR <u>Wm. G. Host</u> ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>			25a. REC'D BY REGISTRAR <u>SEP 16 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



CERTIFICATE OF DEATH

13299

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When these remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN IS <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Western/State Hospital</b>				d. STREET ADDRESS <b>2800 - Shepherd St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Joseph Timothy Carroll</b>				4. DATE OF DEATH Month <b>Sept</b> Day <b>30</b> Year <b>1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/2/1892</b>	9. AGE (In years, last birthday) yrs <b>74</b>	IF UNDER 1 YEAR Months <b>74</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CIT ZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William O. Carroll</b>				14. MOTHER'S MAIDEN NAME <b>? Sweeney</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO		17. INFORMANT Address <b>Mrs. Annette M. Powell (above add-ress)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>144X Carcinoma of mouth with metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastases</b> (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9-30</b> , 19 <b>66</b> to <b>9-30</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9-30</b> , 19 <b>66</b> , and that death occurred at <b>8:30 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Edmund J. Reley</b>				22b. DATE SIGNED <b>9-30-66</b>		22c. PHYSICIAN'S NAME (Type) <b>Western/State Hosp. Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/3/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>				25a. REC'D BY REGISTRAR <b>Oct 5 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
13306									
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Gateway Nursing Home</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>No. Potomac Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Burchell</b> Last <b>Castleman</b>					4. DATE OF DEATH Month <b>September</b> Day <b>27</b> Year <b>1966</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 7, 1898</b>		9. AGE (In years last birthday) <b>68</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Brucetown, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Samuel Castleman</b>					14. MOTHER'S MAIDEN NAME <b>Virginia Aulabaugh</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>232-01-8646</b>		17. INFORMANT <b>Donald R. Castleman-Martinsburg, West Va.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Arteriosclerosis, Coronary</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive C.V. Disease - Pulmonary Embolism</b>									INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>Years</b> <b>Years</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>2 Sept</b> , 19 <b>66</b> , to <b>27 Sept</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>27 Sept</b> 19 <b>66</b> , and that death occurred at <b>3:30</b> AM, from the causes and on the date stated above.									
22a. SIGNATURE <b>[Signature]</b>					22b. DATE SIGNED <b>29 Sept 1966</b>				
22c. PHYSICIAN'S NAME (Type) <b>W. H. Feltz Jr</b>					22d. ADDRESS <b>210 N. Potomac St Hagerstown, Md</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-30-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Norborne Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Martinsburg, Berkeley W. Va.</b>			
24. FUNERAL DIRECTOR <b>Brown Funeral Home</b> ADDRESS <b>Martinsburg, W. Va.</b>					25a. REC'D BY REGISTRAR <b>OCT 3 1966</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				



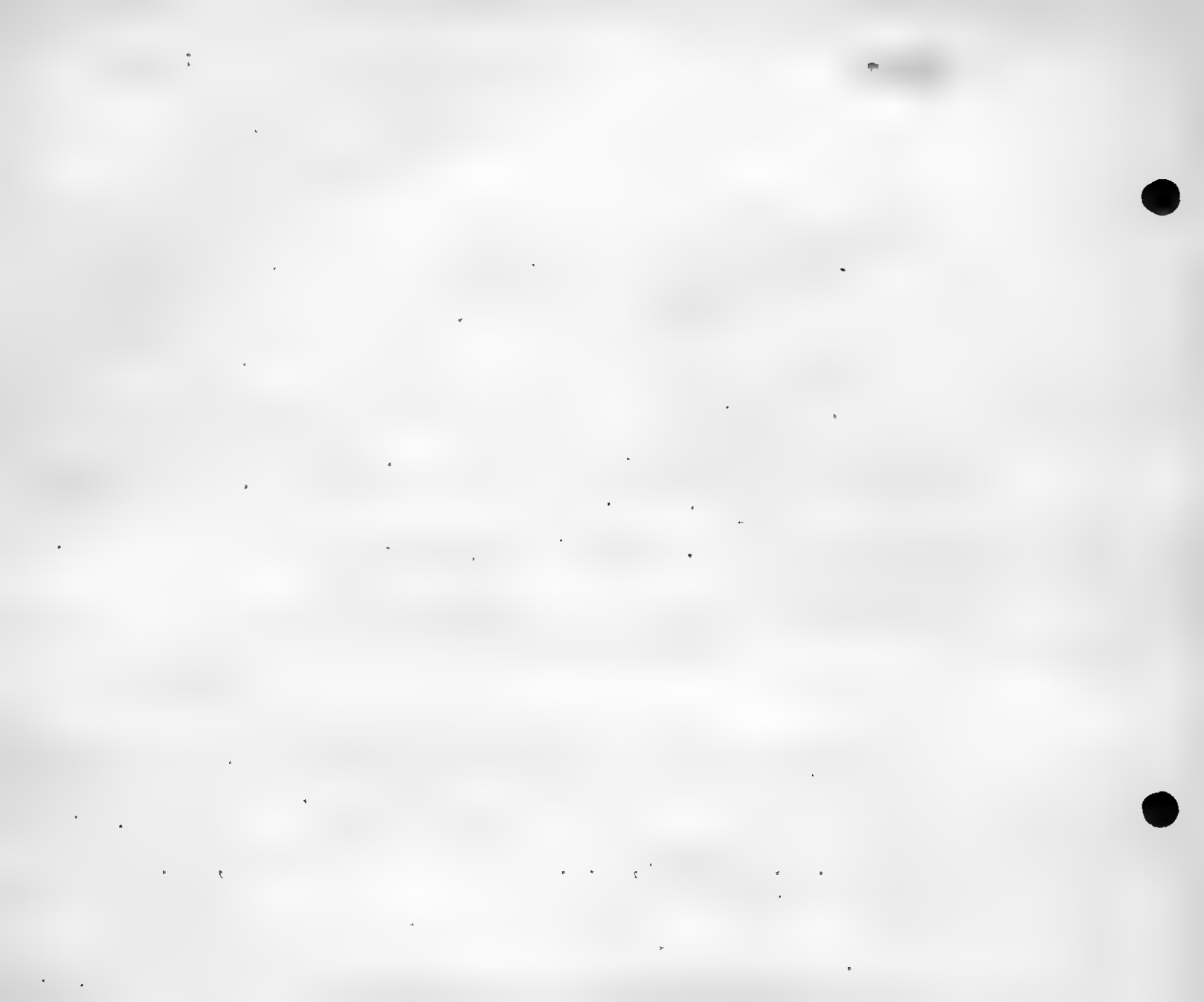
## CERTIFICATE OF DEATH

13301

1 PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>31 Yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>643 Washington Ave</b>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>643 Washington Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROBERT JAMES CAUSER</b> First Middle Last 4. DATE OF DEATH <b>Sept 13 1966</b> Month Day Year		5 SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Apr. 11 1904</b> 9. AGE (In years last birthday) <b>62</b> yrs. IF UNDER 1 YEAR Months Days Hours Min. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crew Dispatcher</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore City Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James F. Causer</b>		14. MOTHER'S MAIDEN NAME <b>Wilhelmina Beattie</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>705-10-6532</b>	
17. INFORMANT <b>Mrs Ethel A. Causer</b>		Address <b>643 Washington Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1. Pulmonary infarction (embolism)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>2. Carcinoma of the rectum with metastasis to the liver</b> DUE TO (c) INTERVAL BETWEEN CAUSE AND DEATH <b>Instant</b> <b>2 1/2 yr.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>March 29, 1966</b> , to <b>Sept. 13, 1966</b> , that (4) (we) last saw the deceased alive on <b>9/13</b> 19 <b>66</b> , and that death occurred at <b>11:45 p.m.</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>B. B. Kneisley</b>		22b. DATE SIGNED <b>Sept. 14, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>		22d. ADDRESS <b>148 West Washington St. Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/17/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Hagerstown Wash Co Md</b>	
24. FUNERAL DIRECTOR <b>Hagerstown Md.</b>		25a. REC'D BY REGISTRAR <b>Andrew K. Coffman Funeral Home Inc</b>	
25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>		DATE <b>SEP 20 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

13302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN lb <b>4 mo.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SUITLAND</b> d. STREET ADDRESS <b>3944 SUITLAND ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>Catherine</b> Middle <b>Lucy</b> Last <b>Costello</b>		4. DATE OF DEATH Month <b>9</b> Day <b>9</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Year <b>1904</b> Month <b>2</b> Day <b>2</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <b>WASHINGTON, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM E. SHEAHAN</b>		14. MOTHER'S MAIDEN NAME <b>ANNA MEADE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>578-09-9768-B</b>	
17. INFORMANT <b>HARRY J. COSTELLO (HUSBAND)</b>		18. ADDRESS OF INFORMANT <b>5911 RYLAND DR. BETHESDA, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobular pneumonia</b> 7201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>myocardial infarction</b> DUE TO (c) <b>atherosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>unknown</b> <b>"</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>① Old cerebral thrombosis ② arteriosclerosis, general</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4-28, 1966</b> to <b>9/9, 1966</b> that (I) (we) last saw the deceased alive on <b>9/9, 1966</b> and that death occurred at <b>8:13 M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Victor L. Ramos, M.D.</b>		22b. DATE SIGNED <b>Sept. 9, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Victor Ramos</b>		22d. ADDRESS <b>1500 Penna. Ave., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>9-12-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT OLIVET CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON, D. C.</b>
24. FUNERAL DIRECTOR <b>Francis J. Collins</b>		25a. REC'D BY REGISTRAR <b>SEP 14 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





## CERTIFICATE OF DEATH

13303

1 PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>33 Yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>164 West Washington St</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>164 West Washington St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>FRANK WARREN COVER</b>		4 DATE OF DEATH Month <b>Sept</b> Day <b>29</b> Year <b>1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 1873</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Distributor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>W.H.R.R.</b>	9 AGE (in years last birthday) <b>94</b> yrs
11. BIRTHPLACE (County & State, or foreign country) <b>Thurmont Fred Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob Henry Cover</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Ann (Unknown)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) (If yes give war or dates of service) <b>C</b>		16 SOCIAL SECURITY NO <b>05-10-6866</b>	
17 INFORMANT <b>Miss Dorothy Cover</b>		Address <b>164 W. Wash St</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized atherosclerosis</b> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>senility</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 16, 1966</b> to <b>death, 1966</b> , that (I) (we) last saw the deceased alive on <b>July 16, 1966</b> , and that death occurred at <b>1:00 PM</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>John C. Stauffer</b>		22b. DATE SIGNED <b>9-30-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>John C. Stauffer, M.D.</b>		22d. ADDRESS <b>145 S. Prospect St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/3/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Wash Co Md</b>
24. FUNERAL DIRECTOR <b>Hagerstown Md. ADDRESS</b> <b>Andrew K. Coffman Funeral Home Inc</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 3 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

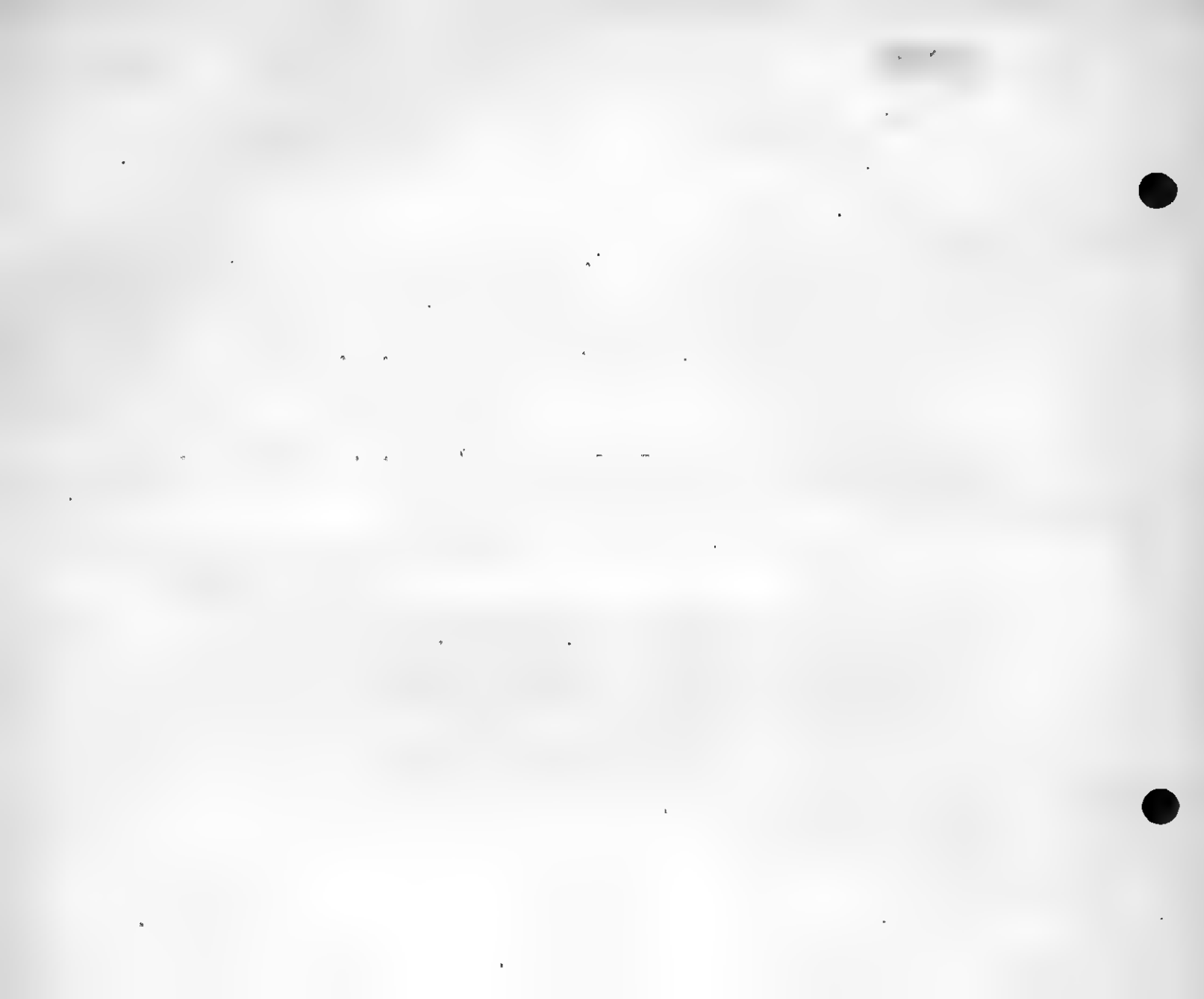


FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and log any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u></u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>13 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ft. Loudon, Pa.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>N.</u> Last <u>Coy</u>			4. DATE OF DEATH Month <u>September</u> Day <u>23</u> Year <u>1966</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/6/16</u>		9. AGE (in years last birthday) <u>50</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal &amp; stone</u>		11. BIRTHPLACE (State or foreign country) <u>Saxton, Pa.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Jesse Coy</u>					14. MOTHER'S MAIDEN NAME <u>Alda Dick</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW II</u>			16. SOCIAL SECURITY NO. <u>193-09-6713</u>		17. INFORMANT <u>Masood F.H., Saxton, Pa.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of spleen</u> <u>736.6</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>fracture of ninth left rib</u> DUE TO (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u> <u>same</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Etiology of / above / being / investigated.</u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pending investigation</u> <u>Victim was trying to stop a fight at the American Legion and was hit by one of them.</u>						
20c. TIME OF INJURY Month, Day, Year Hour <u>X</u> min. <u>Sept 9</u> 19 <u>66</u> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>American Legion</u>		20f. (City or town) (County) (State) <u>Ft. Loudon</u> <u></u> <u>Pa.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Howard N. Weeks</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			9/23/66 22. DATE SIGNED			
EXAMINER'S NAME (Type) <u>Howard N. Weeks, M.D.</u>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			580 Northern Ave. Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Spec. fm) <u>Burial</u>			23b. DATE THEREOF <u>9/25/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fockler Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Saxton, Penna.</u>		
24. FUNERAL DIRECTOR <u>H. R. Ringer</u>			ADDRESS <u>Mercersburg, Pa.</u>			25a. REC'D BY REGISTRAR <u>SEP 26 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	



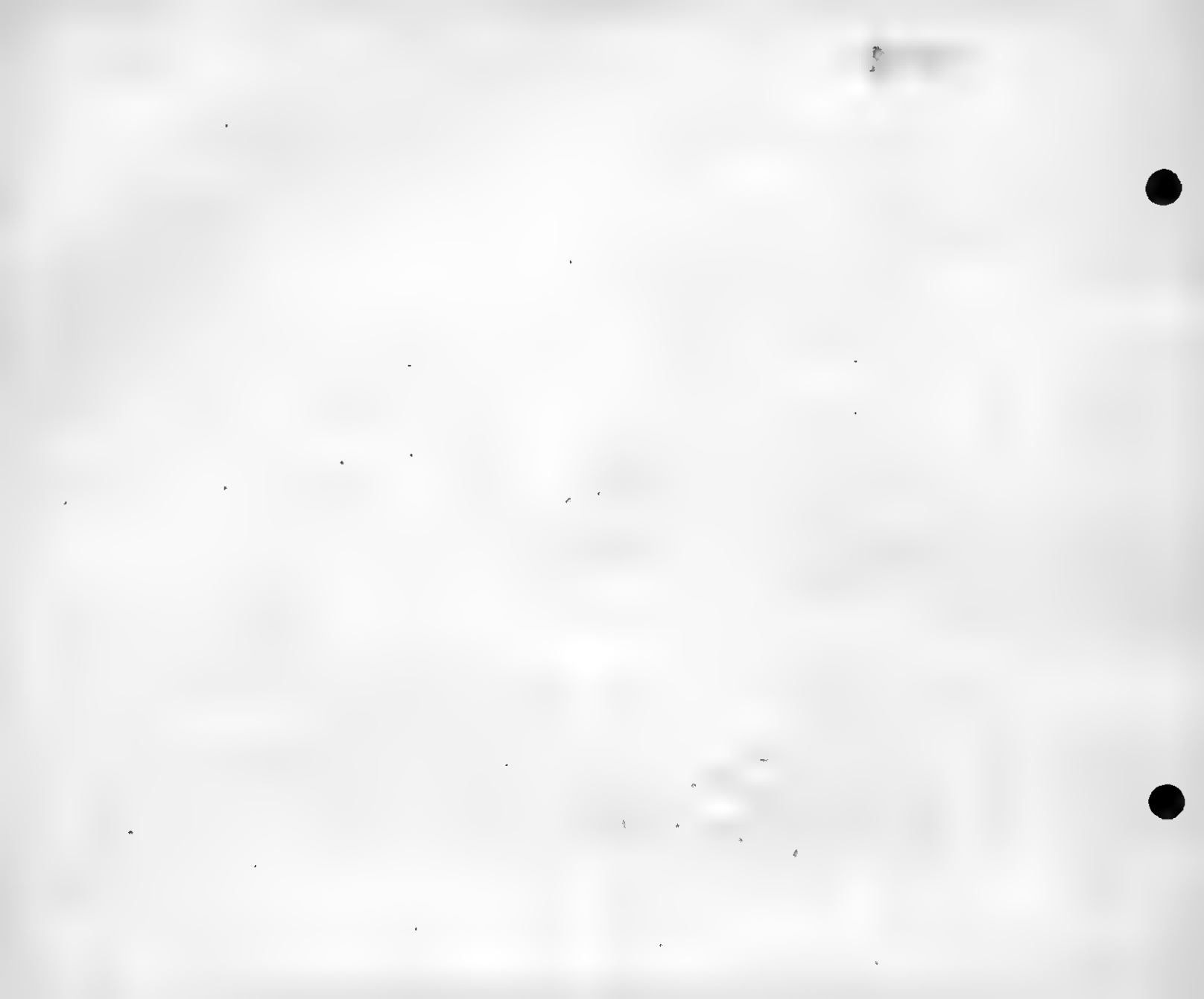
## CERTIFICATE OF DEATH

13305

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 800 Penna Ave	
3. NAME OF DECEASED (Type or print) First Middle Last RALPH MARKWOOD COYLE		4. DATE OF DEATH Month Day Year Sept 27 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 30 1903 63 yrs
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY Public School	
11. BIRTHPLACE (County & State or foreign country) Keedysville Wash Co		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Sylvester Coyle		14. MOTHER'S MAIDEN NAME Florence Rohrer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes		16. SOCIAL SECURITY NO. 232-26-5464	
17. INFORMANT Mrs. Mildred E. Coyle 900 Penna Ave		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Repeated hemorrhage DUE TO Bleeding (b) Duodenal ulcer DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 15 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary emphysema			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 27, 1966, to Sept. 27, 1966, that (I) (we) last saw the deceased alive on Sept. 27, 1966, and that death occurred at 8:00PM, from causes and on the date stated above.			
22a. SIGNATURE [Signature] 22c. PHYSICIAN'S NAME (Type) William T. Layman, M.D.		22b. DATE SIGNED Sept. 27, 1966 22d. ADDRESS 100 Professional Arts Bldg, Hagerstown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 9/30/66	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md
24. FUNERAL DIRECTOR Hagerstown Md. Andrew K. Coffman Funeral Home Inc		25a. REC'D BY REGISTRAR DATE OCT 3 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





## CERTIFICATE OF DEATH

13306

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
c. LENGTH OF STAY IN 1b <u>50 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>761 Spruce St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Marie</u> Last <u>Cressler</u>		4. DATE OF DEATH Month <u>September</u> Day <u>25</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1899</u> 9. AGE (In years last birthday) <u>67</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Keedysville, Md.</u>
12. CIT. ZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Lewis Kindle</u>		14. MOTHER'S MAIDEN NAME <u>Mary Churchey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>217-32-156</u>	
17. INFORMANT <u>Mrs. Dolly Wissinger</u> Address <u>Hagerstown, Md.</u>		308 Nottingham Road	
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Long standing hypertension</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Long standing arteriosclerosis</u> DUE TO <u>Long standing arteriosclerosis</u> (b) <u>Long standing arteriosclerosis</u> (c) <u>Long standing arteriosclerosis</u>			INTERVAL BETWEEN DEATH AND DEATH <u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6:30</u> , 19 <u>66</u> , to <u>Sept 25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept 24</u> , 19 <u>66</u> , and that death occurred at <u>11:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>E. R. Laddisgosh</u>		22b. DATE SIGNED <u>9-26-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. R. Laddisgosh</u>		22d. ADDRESS <u>310 N. TOWNE AVE HAGERSTOWN</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/28/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash. Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. G. Host</u> ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 28 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13307

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>21 mos.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Maryland State Hospital</u>		d. STREET ADDRESS <u>9312 Fontana Drive</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Washington</u> Last <u>Cupp</u>		4. DATE OF DEATH Month <u>September</u> Day <u>6</u> Year <u>19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Dec. 22, 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Weaver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Textile</u>	9. AGE (In years last birthday) <u>86</u> yrs
11. BIRTHPLACE (County & State, or foreign country) <u>Jacksonville, Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Cupp</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Stewart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>246-09-5823</u>	17. INFORMANT <u>Charles J. Cupp 609 Charles Ave. Charlotte,</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobular pneumonia</u> DUE TO <u>Pulmonary emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10 yrs</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above			
22a. SIGNATURE <u>Edwin G. Riley</u>		22b. DATE SIGNED <u>9-7-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edwin G. Riley</u>		22d. ADDRESS <u>1500 Penna Ave, Hagerstown</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal &amp; Burial</u>	23b. DATE THEREOF <u>9/9/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Charlotte Mecklenburg, N.C.</u>
24. FUNERAL DIRECTOR <u>Wm. G. Horst</u> <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 8 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles J. Cupp</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13308

1 PLACE OF DEATH a COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Washington</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c LENGTH OF STAY IN 1b <u>56 yrs.</u>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>228 S. Locust St.</u>		d STREET ADDRESS <u>228 S. Locust St.</u>	
3 NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Clayton</u> Last <u>Deaver</u>		4 DATE OF DEATH Month <u>September</u> Day <u>29</u> Year <u>19 66</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 16, 1890</u>
9 AGE (in years last birthday) <u>76</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Buildings</u>	
11 BIRTHPLACE (State or foreign country) <u>Rileyville, Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Deaver</u>		14 MOTHER'S MAIDEN NAME <u>Jennie Walker</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>217-10-2803</u>	
17 INFORMANT <u>Mrs. Ollie Deaver</u>		Address <u>Hagerstown, Md.</u> <u>228 S. Locust St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Aneurysm</u> DUE TO (b) <u>Arteriosclerosis, generalized and</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH <u>30 mins</u> <u>20 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Prostatic Hypertrophy, Benign</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Edward W. Ditto, III</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Edward W. Ditto, III, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>Hagerstown, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>10/2/66</u>	23c NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d LOCATION (City or town) (County) (State) <u>Hagerstown Washington Md.</u>
24 FUNERAL DIRECTOR <u>Wm. C. Hoot</u> <u>Rest Haven Funeral Chapel</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 4 1966</u>	



## CERTIFICATE OF DEATH

13309

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>2 Days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Knoxville Rfd. 2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>Brownsville</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Annie Catherine Deener</b>		4. DATE OF DEATH Month Day Year <b>September 12, 19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 1, 1869</b>
9. AGE (In years last birthday) <b>96 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>10 11</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Burkettsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Mason Coulter</b>		14. MOTHER'S MAIDEN NAME <b>Julia Gordon</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Mrs. John Jennings, Brownsville, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>STRANGULATED HERNIA</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>6 DAYS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CORONARY INSUFFICIENCY</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9-10-66</b> , 19__, to <b>9-12-66</b> , 19__, that (I) (we) last saw the deceased alive on <b>9-12-66</b> , 19__, and that death occurred at <b>1-30 AM</b> , from causes and on the date stated above			
22a. SIGNATURE <i>J.R. Dwyer</i>		22b. DATE SIGNED <b>9-13-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. R. DWYER, M.D.</b>		22d. ADDRESS <b>19 KING ST., HAGERSTOWN, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9-14-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Brownsville Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Brownsville, Md.</b>
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 15 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13310

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>24 High St.</u>					d. STREET ADDRESS <u>24 High St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <u>Belva</u> Middle <u>Gay</u> Last <u>Derr</u>				4 DATE OF DEATH Month <u>September</u> Day <u>4</u> Year <u>19 66</u>			
5 SEX <u>Female</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>July 18, 1897</u>	
9. AGE (In years last birthday) yrs <u>69</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Venton Luther Palmer</u>			
14. MOTHER'S M.A.DEN NAME <u>Martha Jane Smith</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>212-14-6311</u>				17. INFORMANT <u>Mr. C.O. Derr 24 High St. Hagerstown, Md.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Hypertensive Cardio Vascular Disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Recent</u>  <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>66</u> , to <u>Sept. 4</u> , 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>Aug. 26</u> , 19 <u>66</u> , and that death occurred at <u>6 P.</u> M., from causes and on the date stated above.							
22a. SIGNATURE <u>E. W. Ditto, Jr.</u>						22b. DATE SIGNED <u>9-6-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>						22d. ADDRESS <u>215 W. Washington St., Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/7/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash. Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. G. Horok</u> <u>Rest Haven Funeral Chapel</u>				25a. REC'D BY REGISTRAR <u>SEP 8 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



FOR STATE  
HEALTH DEPT.

TO CITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PNC3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 (M)  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13311

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Silver Spring MD</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>120 Greenhill Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hagerstown MD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DENNIS</u> Middle <u>L</u> Last <u>DHERIT</u>	4. DATE OF DEATH Month <u>Sept</u> Day <u>4</u> Year <u>1966</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 5 1946</u>
9. AGE (in years last birthday) <u>20</u> yrs.		IF UNDER 1 YEAR: Months <u>20</u> Days <u>20</u> Hours <u>20</u> Min. <u>20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>W. H. Dherit</u>		14. MOTHER'S MAIDEN NAME <u>Lillian M. Krueger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>174-36-6454</u>	
17. INFORMANT <u>Mrs Paul Shaffer</u>		Address <u>120 Greenhill Drive Hagerstown MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>FRACTURED SKULL</u> DUE TO (b) <u>INTRA-ABDOMINAL HEMORRHAGE</u> DUE TO (c) <u>FRACTURED LEFT FEMUR</u> SEVERE LACERATIONS OF LEG & FACE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>IN COLLISION WITH ONCOMING CAR</u>	
20c. TIME OF INJURY Month, Day, Year <u>12:15 a.m. 9-4 66</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>STATE RT 65</u>	20f. (City or town) (County) (State) <u>FAIRPLAY, WASH. MD.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dr. E. W. Ditto</u>		22. DATE SIGNED <u>9-4-66</u>	
EXAMINER'S NAME (Type) <u>DR. E. W. DITTO</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept 7 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FISSELS</u>		23d. LOCATION (City, town or county) (State) <u>Glen Rock Pa Pa</u>	
24. FUNERAL DIRECTOR <u>H.C. Geiple</u>		25a. REC'D BY REGISTRAR <u>SEP 7 1966</u>	
ADDRESS <u>GLEN ROCK, PA</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11 12 11

PLEASE PRINT NAME AND ADDRESS  
OF THE PERSON TO WHOM THIS  
LETTER IS TO BE SENT

12:15 1-2 X  
STREET  
CITY, STATE, ZIP

X

U.S. AIR MAIL  
FIRST CLASS

## CERTIFICATE OF DEATH

13312

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> c. LENGTH OF STAY IN 1b <u>9 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Williamsport sanatorium</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>609 Frederick St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>MARGARET</u> Last <u>DICK</u>		4 DATE OF DEATH Month <u>September</u> Day <u>18</u> Year <u>19 66</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Aug 26 1876</u>
9. AGE (In years last birthday) <u>90</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Hagerstown Wash Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Doarnberger</u>		14. MOTHER'S MAIDEN NAME <u>Mary Purcell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>-----</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Charlotte Bellomy</u>		Address <u>310 Frederick St</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Arteriosclerotic cardio-vascular</u> DUE TO (c) <u>Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arricular Fibrillation</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) this hospital attended the deceased from <u>9-17</u> , 19 <u>66</u> to <u>9-17</u> , 19 <u>66</u> that (2) (we) last saw the deceased alive on <u>9-17</u> , 19 <u>66</u> , and that death occurred at <u>  </u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>M.E. Byrkit</u>		22b. DATE SIGNED <u>9-18-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u>		22d. ADDRESS <u>Williamsport Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/21/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash Co Md.</u>	
24. FUNERAL DIRECTOR <u>Andrew K. Coffman Funeral Home Inc</u>		25a. REC'D BY REGISTRAR <u>SEP 21 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

CERTIFICATE OF DEATH

13313

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 Week</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garlock Nursing Home</b>		d. STREET ADDRESS <b>1101 Maugans Ave</b>	
3 NAME OF DECEASED (Type or print) <b>LESTER BREWER DRAPER</b>		4 DATE OF DEATH Month <b>Sept</b> Day <b>14</b> Year <b>1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>June 27 1885</b>
9. AGE (in years last birthday) <b>81</b> yrs		10. IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Freight Conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Williamsport Wash Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Daniel S. Draper</b>		14. MOTHER'S MAIDEN NAME <b>Florence Wolford</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>717-07-9384</b>	
17. INFORMANT <b>Miss Anna L. Draper</b>		Address <b>1101 Maugans Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Advanced Arteriosclerosis, generalized</b> DUE TO (c) <b>Emphysema</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prostatic Hypertrophy, Benign</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 6, 1966</b> , to <b>Sept 14, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 13, 1966</b> , and that death occurred at <b>2:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Edward W. Ditto III</b>		22b. DATE SIGNED <b>9-14-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III, M.D.</b>		22d. ADDRESS <b>217 West Washington Street Hag., Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9/16/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Hagerstown Wash Co Md</b>
24. FUNERAL DIRECTOR <b>Andrew K. Coffman Funeral Home Inc</b>		25a. REC'D BY REGISTRAR <b>SEP 20 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13314

<b>1 PLACE OF DEATH</b> a. COUNTY <u>Washington</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN <u>13 1/2</u> days c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>74 Madison Ave., Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. STREET ADDRESS f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3 NAME OF DECEASED</b> (Type or print) <u>Michael NMN Farrie</u>		<b>4. DATE OF DEATH</b> Month <u>September</u> Day <u>16</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1904</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania (McKeesport)</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Joseph Farrie</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Cario Valentine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>705-10-4732</u>	
17. INFORMANT <u>Mrs. Michael Farrie</u>		Address <u>Hagerstown, Md.</u> <u>74 Madison Ave.</u>	
<b>18. CAUSE OF DEATH</b> (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, gallbladder with extensive liver met.</u> DUE TO (b) <u>  </u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 13, 1966</u> , to <u>Sept. 16, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept. 15, 1966</u> , and that death occurred at <u>7:45 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>J. H. Kehne, M. D.</u>		22b. DATE SIGNED <u>9-16-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. H. Kehne, M. D.</u>		22d. ADDRESS <u>1229 Ravenwood Hts., Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/19/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Hagerstown Wash. Md.</u>
24. FUNERAL DIRECTOR <u>Wm. C. Hunt</u> <u>Rest Haven Funeral Chapel, Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>SEP 13 1966</u> <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
3321 CERTIFICATE OF DEATH 13315										
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>18 days</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>					d. STREET ADDRESS <b>126 Fairground Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANN MATILDA FAULKNER</b>					4. DATE OF DEATH Month Day Year <b>Sept. 26 19 66</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 13, 1886</b>		9. AGE (In years last birthday) <b>80 yrs.</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Weaver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hosiery Mill</b>		11. BIRTHPLACE (County & State or foreign country) <b>Washington, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>CHARLES FAUGHANDER</b>					14. MOTHER'S MAIDEN NAME <b>ANN GROSCH</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>214-09-4274</b>		17. INFORMANT <b>2617 S. Holbrook St. Fred Faughander Philadelphia, Pa.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b> DUE TO <b>Congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Arteriosclerotic heart disease</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of left breast</b>									INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. - p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>		20f. (City or town) (County) (State) <b>- - -</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>Aug</b> , 19 <b>61</b> , to <b>Sept. 26</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Sept. 26</b> 19 <b>66</b> and that death occurred at <b>A</b> M, from the causes and on the date stated above.										
22a. SIGNATURE <i>Harold R. Ritch, Jr.</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9-26-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Harold R. Ritch, Jr.</b>					22d. ADDRESS <b>302 N. Potomac St Hagerstown, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 29, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Williamsport, Maryland</b>			
24. FUNERAL DIRECTOR <b>Albert L. Leaf Williamsport, Md.</b>					25a. REC'D BY REGISTRAR <b>SEP 29 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

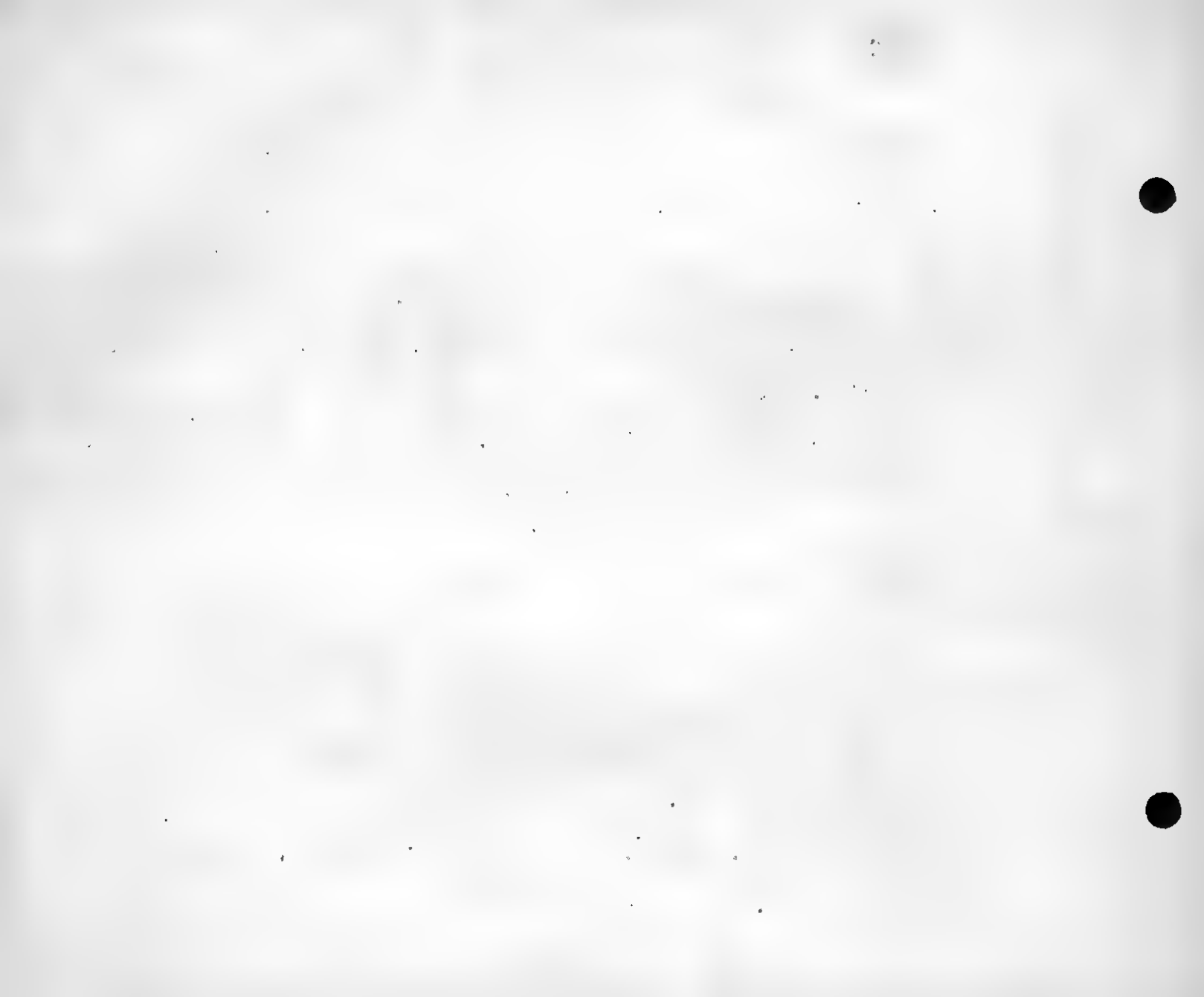


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13316											
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>						d. STREET ADDRESS <b>650 OAK HILL AVE.</b>					
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>FRANKLIN</b> Last <b>FLEAGLE</b>						4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>14</b> Year <b>19 66</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 22, 1890</b>		9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MERCHANT</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>STORE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>SAMUEL J. FLEAGLE</b>						14. MOTHER'S MAIDEN NAME <b>FLORENCE H. SPAHR</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>217-32-5341</b>		17. INFORMANT <b>HAGERSTOWN, MARYLAND</b> <b>MRS. ETHEL FLEAGLE 650 OAK HILL AVE.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis, Recurrent</b> DUE TO (b) <b>Cerebral Atherosclerosis</b> DUE TO (c) <b>Hypertension and its Vascular Lesions</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> <b>1 year</b> <b>16 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>12-9</b> , 19 <b>47</b> to <b>9-14</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9-14</b> , 19 <b>66</b> , and that death occurred at <b>1:55 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Dalton M. Welty</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9/16/1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>DALTON M. WELTY M.D.</b>						22d. ADDRESS <b>998 POTOMAC AVE. HAGERSTOWN, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9/17/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR LAWN CEMETERY</b>			23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN, MD.</b>				
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER HAGERSTOWN, MARYLAND</b>						25a. REC'D BY REGISTRAR <b>SEP 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

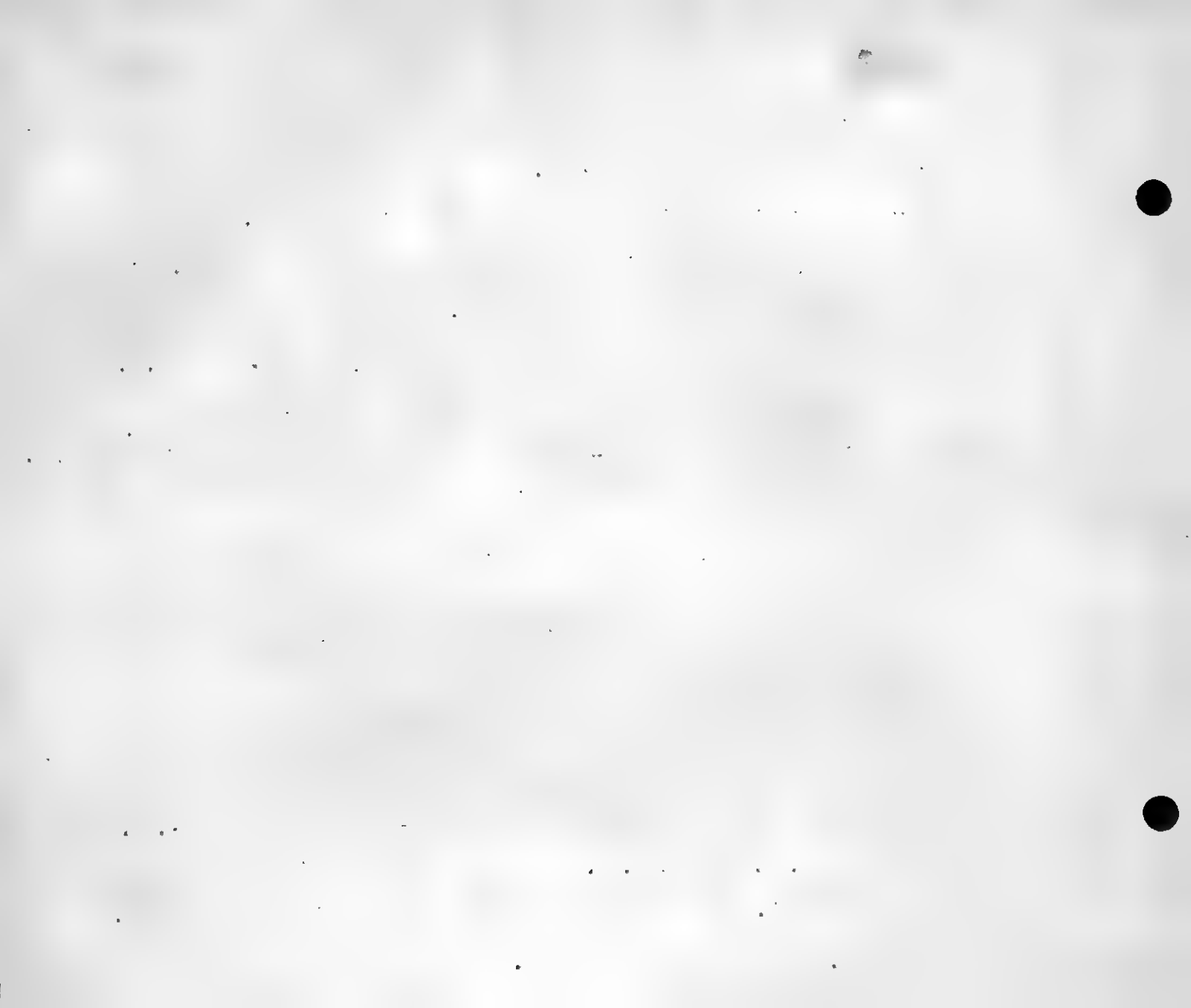
VR AIS (4)  
20M 1/65

BP

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

13317

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>16 hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>626 Potomac Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>KATHRYN</b> Last <b>FLEMING</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>13</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 12 1896</b>
9. AGE (in years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public Schools</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Williamsport Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Fleming</b>		14. MOTHER'S MAIDEN NAME <b>Anna Nora Fleming</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-36-3799</b>	
17. INFORMANT <b>Miss Ethel M Rinehart</b>		<b>626 Potomac Ave. Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO (b) <b>Coronary Atherosclerosis</b> DUE TO (c) <b>—</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b> <b>4 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Acute broncho-spasm &amp; edema</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>August</b> , 19 <b>68</b> , to <b>Sept 13</b> , 19 <b>66</b> , that (I) <b>over</b> last saw the deceased alive on <b>Sept 13</b> , 19 <b>66</b> , and that death occurred at <b>1P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>M. E. Byrkit</b>		22b. DATE SIGNED <b>9.15.66</b>	
22c. PHYSICIAN'S NAME (Type) <b>M. E. Byrkit, M. D.</b>		22d. ADDRESS <b>Williamsport Maryland 21795</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 15-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Williamsport Md.</b>	
24. FUNERAL DIRECTOR <b>Albert L. Leaf</b>		25a. REC'D BY REGISTRAR <b>SEP 19 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13318

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN lb <u>42 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. STREET ADDRESS <u>625 Maryland Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Estie</u> Last <u>Johner</u>		4. DATE OF DEATH Month <u>September</u> Day <u>27</u> Year <u>19 66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 28, 1892</u>
9. AGE (In years last birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
13. BIRTHPLACE (County & State, or foreign country) <u>Augusta County, Va.</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. FATHER'S NAME <u>James Elyard</u>		16. MOTHER'S MAIDEN NAME <u>Mahalia Bolton</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		18. SOCIAL SECURITY NO <u>None</u>	
19. INFORMANT <u>Mr. Wm. G. Johner</u>		Address <u>625 Maryland Ave. Hagerstown, Md.</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS - GENERALIZED</u> <u>1750</u> DUE TO Conditions (if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>CARCINOMA OVARY</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>74 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>58</u> , to <u>SEPT 27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>SEPT 27</u> , 19 <u>66</u> , and that death occurred at <u>8:10 AM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Archie Robert Cohen</u>		22b. DATE SIGNED <u>09-28-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ARCHIE ROBERT COHEN M.D.</u>		22d. ADDRESS <u>CLEAR SPRING - MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/29/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash. Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. G. Stark</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
Address <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



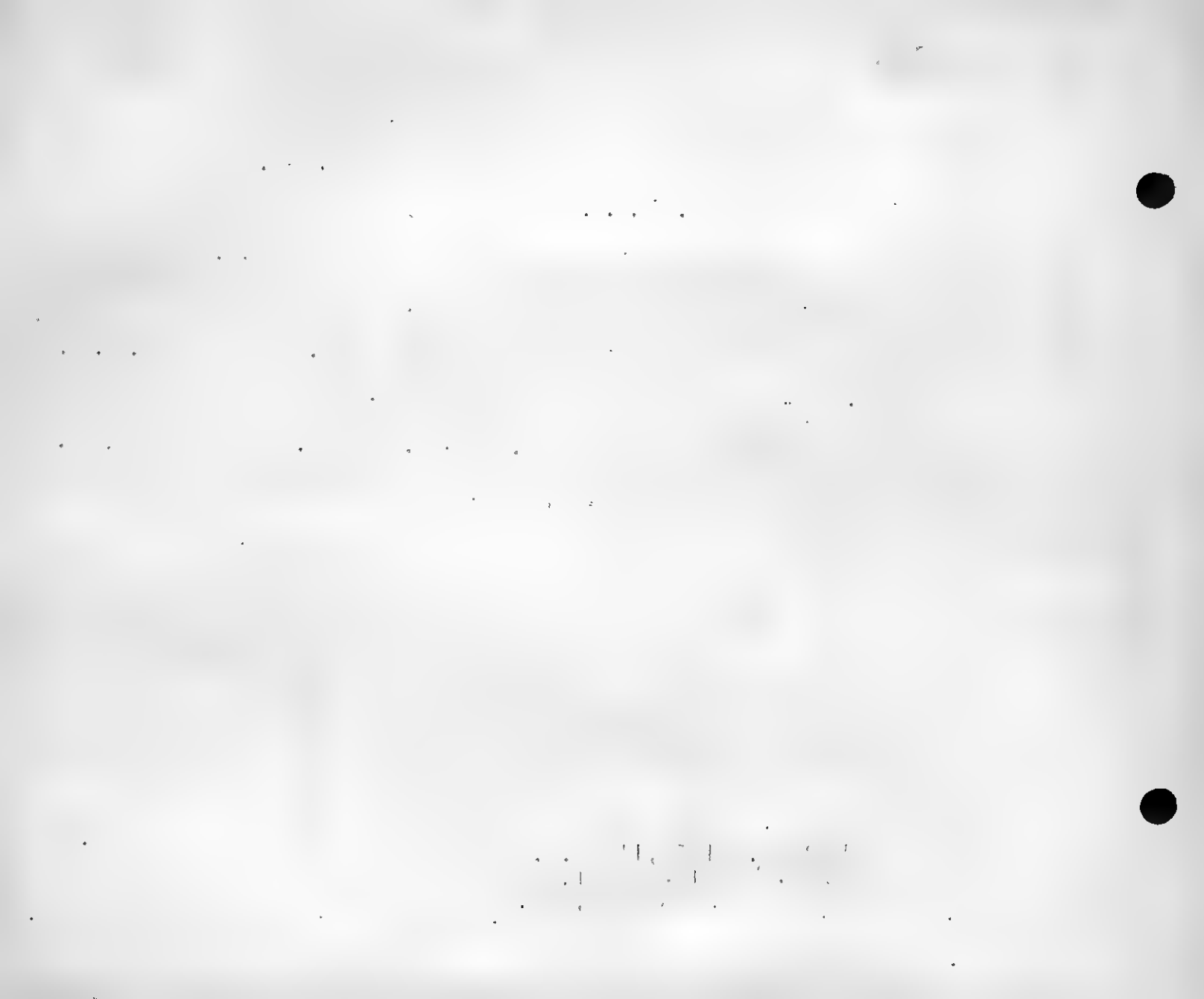
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13313  
MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Washington</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Allegany</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland, Rt. # 1</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington County Hosp. (D.O.A.)</i>		d. STREET ADDRESS <i>Homewood Addition</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>Forrest</i> Last <i>Folk</i>		4. DATE OF DEATH Month <i>Sept.</i> Day <i>1</i> Year <i>19 66</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>March 21, 1933</i>
9. AGE (In years last birthday) <i>33</i> yrs.		IF UNDER 1 YEAR Months <i>33</i> Days <i>33</i> Hours <i>33</i> Min. <i>33</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	
11. BIRTHPLACE (State or foreign country) <i>Cumberland, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>David J. Folk</i>		14. MOTHER'S MAIDEN NAME <i>Nina E. Long</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes give war or dates of service) <i>2/10/53-2/9/57</i>		16. SOCIAL SECURITY NO. <i>217-28-9391</i>	
17. INFORMANT <i>Mr. David J. Folk</i>		Address <i>Rt. # 1 Cumberland, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Crushing Injury to chest and</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (b) <i>Abdomen, with Massive Internal</i> DUE TO (c) <i>Injuries</i>		INTERVAL BETWEEN ONSET AND DEATH <i>30 Min</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Struck and crushed by Steam Roller</i>	
20c. TIME OF INJURY Month, Day, Year <i>8:30 a.m. 9/1/66</i>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Route #40</i>		20f. (City or town) (County) (State) <i>Hancock Wash Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <i>Edward W. Ditto III</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>EDWARD W. DITTO, III M.D.</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED <i>9/1/66</i>		Address (Street, city, town, or county) <i>217 W. WASHINGTON ST.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>9/4/66</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>HAGERSTOWN, MD</i>		23d. LOCATION (City, town or county) (State) <i>Cumberland, Allegany Md.</i>	
24. FUNERAL DIRECTOR <i>H. Wayne George</i>		25a. REC'D BY REGISTRAR <i>SEP 3 1966</i>	
ADDRESS <i>Cumberland, Maryland</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

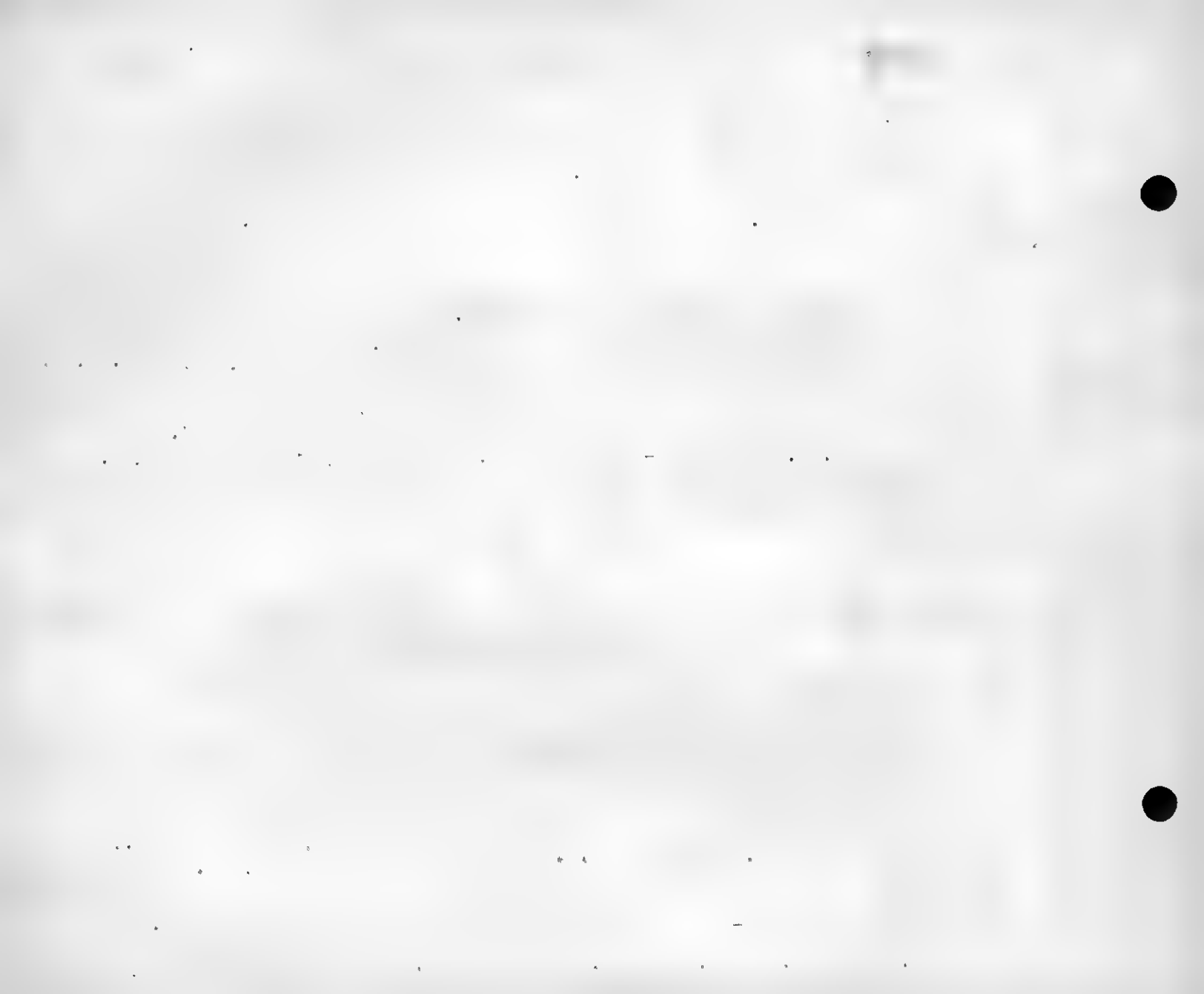
VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

13320

1 PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN lb <b>8 Yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>908 Hamilton Blvd.</b>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>908 Hamilton Blvd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Grover Lee Ford</b>		4 DATE OF DEATH Month <b>September 9,</b> Day <b>19</b> Year <b>66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Oct. 2, 1894</b>
9 AGE (In years last birthday) <b>71</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railway Mail Clerk</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Mail</b>		11 BIRTHPLACE (County & State, or foreign country) <b>Md. Clevelandville, Wash. Co.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Samuel Ford</b>	
14. MOTHER'S MAIDEN NAME <b>Maria Haupt</b>		15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W. W. One</b>	
16 SOCIAL SECURITY NO <b>578-50-5837</b>		17. INFORMANT <b>Hagerstown, Md. Mrs. Nellie Ford, 908 Hamilton Blvd.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO <b>Atherosclerotic (Coronary) Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH, <b>Five minutes</b> <b>9 years</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of prostate</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>4-29, 1959</b> , to <b>9-9, 1966</b> , that (I) (we) last saw the deceased alive on <b>9-9-1966</b> , and that death occurred at <b>130 A.M.</b> from causes and on the date stated above.	
22a. SIGNATURE <b>John H. Hornbaker</b>		22b. DATE SIGNED <b>9-10-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b>		22d. ADDRESS <b>154 W. Washington St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-11-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Boonsboro, Md.</b>	
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		25. REC'D BY REGISTRAR <b>SEP 15 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



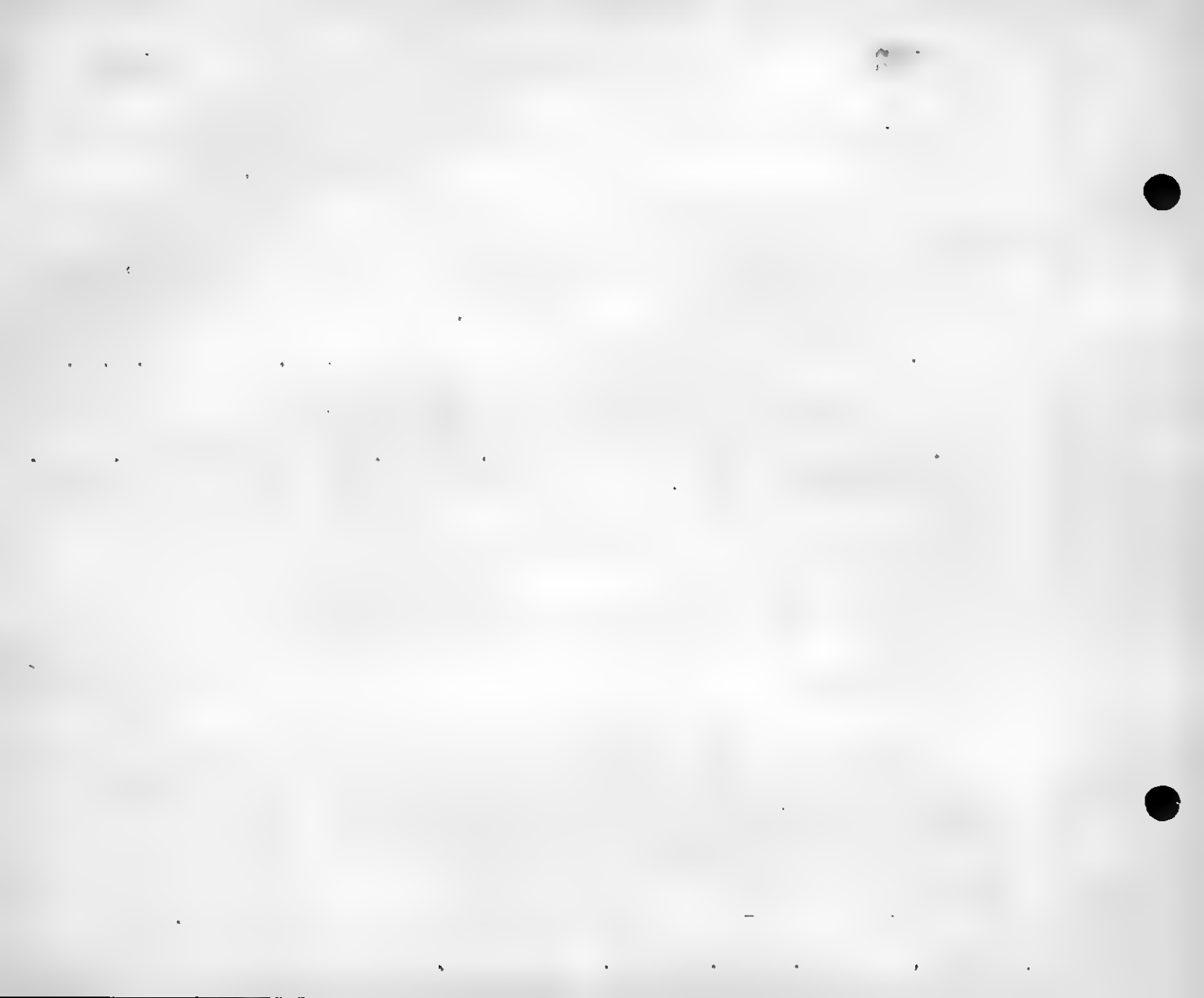
CERTIFICATE OF DEATH

13322

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>4 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Boonsboro Rfd. 2</b> d. STREET ADDRESS <b>Mapleville</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Blanche May Gross</b>		4. DATE OF DEATH Month Day Year <b>September 20, 19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 20, 1900</b>
9. AGE (In years last birthday) <b>66</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Mapleville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Cunningham</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude Gantz</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Mr. Elmer T. Gross, Boonsboro Rfd. 2, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Liver</b> DUE TO (b) <b>Embolus</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 17, 1966</b> to <b>Sept 20, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 20, 1966</b> , and that death occurred at <b>9:15</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>G. W. LeVan</b>		22b. DATE SIGNED <b>9/21/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. W. LeVan</b>		22d. ADDRESS <b>Boonsboro, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9-23-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Boonsboro, Md.</b>
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 27 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



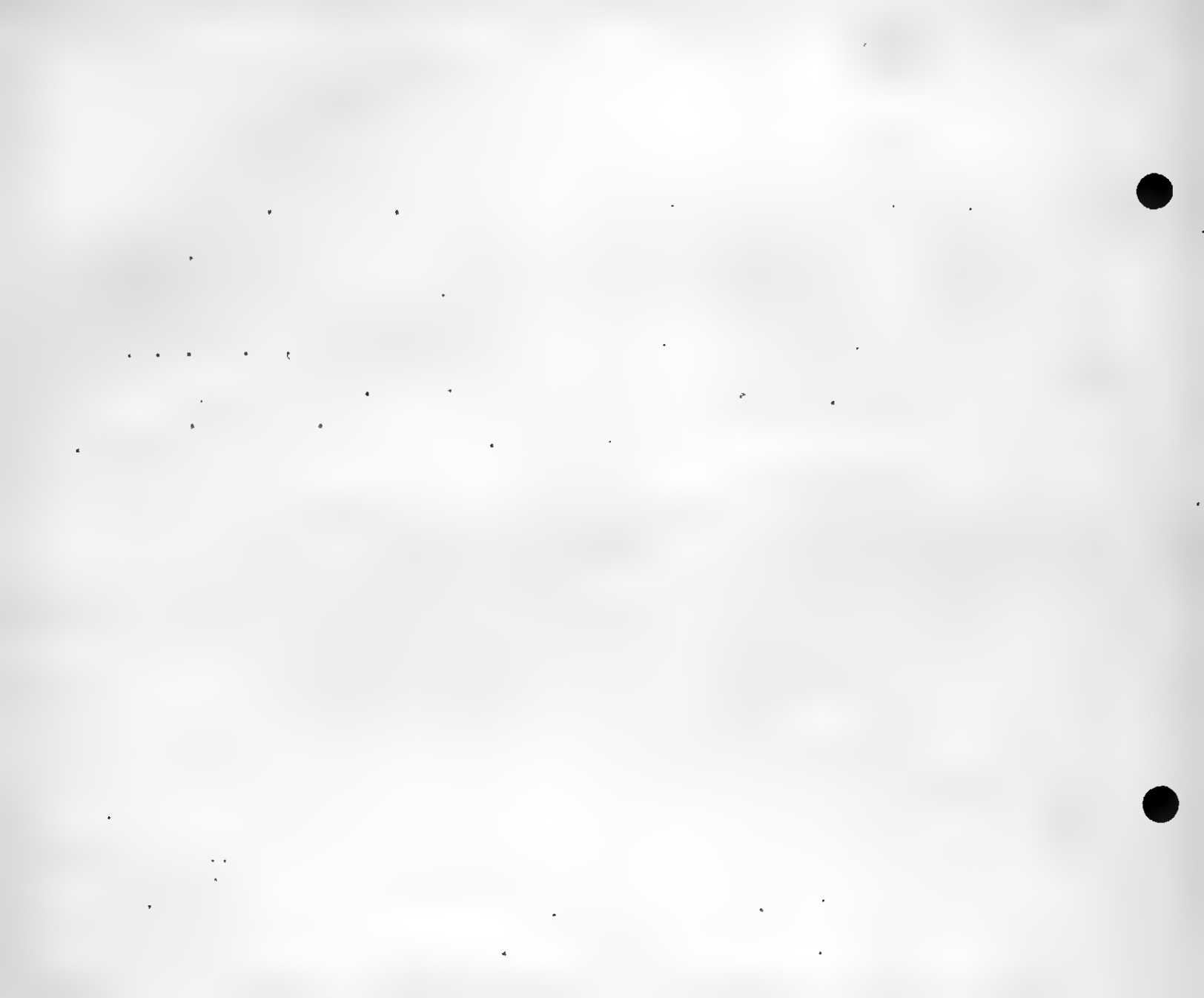


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13323											
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY in 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharpsburg</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>						d. STREET ADDRESS <b>135 W. Main St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Elizabeth</b> Last <b>Gross</b>						4. DATE OF DEATH Month <b>Sept.</b> Day <b>21</b> Year <b>1966</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 2 1931</b>		9. AGE (In years last birthday) <b>35</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>18</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitorial Service</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Mack Truck</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Shepherdstown, W. Va.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel F. Swope</b>						14. MOTHER'S MAIDEN NAME <b>Lottie Blanche Breeben</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>214 28 7436</b>		17. INFORMANT <b>135 W. Main St.</b> <b>Mr. Gerald Gross Sharpsburg Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Massive subarachnoid hemorrhage</b> DUE TO (c) <b></b>										INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>9-20-66</b> , 19 <b></b> , to <b>9-21-66</b> , 19 <b></b> , that (I) (we) last saw the deceased alive on <b>9-21-66</b> , 19 <b></b> , and that death occurred at <b>1:20 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>A. F. Abdullah</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9-22-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>A. F. Abdullah, M. D.</b>						22d. ADDRESS <b>132 N. Potomac St., Hagerstown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 24-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Hagerstown Maryland</b>					
24. FUNERAL DIRECTOR <b>Albert L. Leaf Williamsport Md.</b>						25a. REC'D BY REGISTRAR <b>SEP 26 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit file, pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13321

1 PLACE OF DEATH a COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, f. institution, Residence before admission) a STATE <b>W. Va.</b> b COUNTY <b>Jefferson</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c LENGTH OF STAY IN 1b <b>Charles Town</b>	
d NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d STREET ADDRESS <b>Box 386</b>	
3 NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>Lee</b> Last <b>Grim</b>		4 DATE OF DEATH Month <b>Sept.</b> Day <b>24</b> Year <b>1966</b>	
5 SEX <b>M</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>11/23/16</b>
9 AGE (in years last birthday) <b>49</b> yrs		10 IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Groom</b>		11b KIND OF BUSINESS OR INDUSTRY <b>Horse racing</b>	
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		13 BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13 FATHER'S NAME <b>Esau Grim</b>		14 MOTHER'S MAIDEN NAME <b>Susie Lackey</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT <b>Clarence Grim, Berryville, Va.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Aspiration + pneumonia</b> DUE TO (b) <b>convulsive seizures + D.T.'s</b> DUE TO (c) <b>alcoholism, needle &amp; chronic</b>		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>3 days</b> <b>years</b>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>cerebral concussion</b>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <b>Dugget + thrown by a horse AT Hagerstown</b>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>at Hagerstown</b>	
20c TIME OF INJURY Month, Day, Year <b>9/21/66</b>		20d INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Race Track</b>		20f (City or town) (County) (State) <b>Hagerstown Wash MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles J. Benders</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>H.N. WEEKS</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED <b>9/24/66</b>		Address (Street, city, town, or county) <b>Hagerstown, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>9/27/66</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Berryville, Virginia</b>	
24 FUNERAL DIRECTOR <b>Charles J. Benders - Berryville</b>		25a REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>Berryville, Va.</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>OCT 7 1966</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> WASHINGTON <b>MARYLAND</b> <b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN <b>c. LENGTH OF STAY IN 1b</b> 1 MONTH <b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) GARLOCK CONV. HOME					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) <b>a. STATE</b> MARYLAND <b>b. COUNTY</b> WASHINGTON <b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN <b>d. STREET ADDRESS</b> 974 JEFFERSON BLVD. <b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last FRANCIS JOSEPH HAMBURG			<b>4. DATE OF DEATH</b> Month Day Year SEPTEMBER 20 19 66						
<b>5. SEX</b> MALE	<b>6. COLOR OR RACE</b> WHITE	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> FEBRUARY 13, 1889	<b>9. AGE</b> (In years last birthday) 77 yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) RETIRED MACHINIST		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> RAILROAD		<b>11. BIRTHPLACE</b> (County & State, or foreign country) BLAIR CO., PENNA.	<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.				
<b>13. FATHER'S NAME</b> CHARLES F. HAMBURG			<b>14. MOTHER'S MAIDEN NAME</b> ANNA RENNETT						
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) NO		<b>16. SOCIAL SECURITY NO.</b> 705-10-6577		<b>17. INFORMANT</b> HAGERSTOWN, MARYLAND MRS. JACK COMER 974 JEFFERSON BLVD.					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> Hypostatic pneumonia - due to <b>INTERVAL BETWEEN ONSET AND DEATH</b> 5 days. <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b> <b>DUE TO</b> (b) Nephrosclerosis & Advanced Arterio-sclerosis <b>25 yrs</b> <b>DUE TO</b> (c) Sclerotic Vascular Disease.					<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> Inguinal Hernia, Bilateral - (4 Paget's Disease Pubis).				
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)						
<b>21. I certify that (I) (this hospital) attended the deceased from July 28, 1966, to Sept 20, 1966, that (I) (we) last saw the deceased alive on Sept 20, 1966, and that death occurred at 5:20 P.M. from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> Edward W. Ditto, III, M.D.			<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>	<b>22b. DATE SIGNED</b> 9/21/1966					
<b>22c. PHYSICIAN'S NAME (Type)</b> EDWARD W. DITTO, III, M.D.			<b>22d. ADDRESS</b> 219 W. WASHINGTON ST., HAGERSTOWN, MD.						
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) BURIAL	<b>23b. DATE THEREOF</b> SEPT. 23, 1966	<b>23c. NAME OF CEMETERY OR CREMATORY</b> REST HAVEN CEM.	<b>23d. LOCATION</b> (City, town or county) (State) HAGERSTOWN, MARYLAND						
<b>24. FUNERAL DIRECTOR</b> CHARLES M. ROUZER HAGERSTOWN, MARYLAND			<b>25a. REC'D BY REGISTRAR</b> SEP 27 1966	<b>25b. REGISTRAR'S SIGNATURE</b> Judge					



## CERTIFICATE OF DEATH

13325

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Washington</i>		MARYLAND		STATE <i>Virginia</i>		COUNTY <i>Loudoun</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Hagerstown</i>		LENGTH OF STAY (in this place) <i>1 day</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Lovettsville (Rural)</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Washington County Hospital</i>				STREET ADDRESS (If rural give location) <i>RFD# 1, Lovettsville, Va.</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <i>JAMES RICHARD HARDING</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>Sent. 23, 1966</i>			
<b>5. SEX</b> <i>Male</i>	<b>6. COLOR OR RACE</b> <i>White</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>Married</i>	<b>8. DATE OF BIRTH</b> <i>Aug. 12, 1912</i>		<b>9. AGE last birthday</b> <i>54 yrs.</i>	<b>IF UNDER 1 YEAR</b> (Month) (Day) (Year) <b>IF UNDER 24 HRS.</b> (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if done during part of life) <i>Track Foreman (Ret.)</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Railroad</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Harpers Ferry, W.Va.</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA</i>	
<b>13. FATHER'S NAME</b> <i>James Marion Harding</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Katie Mae Springer</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>No</i>		<b>16. SOCIAL SECURITY NO.</b> <i>4-251-12-9345</i>		<b>17. INFORMANT &amp; ADDRESS</b> <i>Mrs. Velma Harding RFD#1, Lovettsville, Va. 22080</i>			
<b>18. MEDICAL CERTIFICATION</b>						<b>DATE OF ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
IMMEDIATE CAUSE (A) <i>pulmonary failure</i>						<i>weeks</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>bronchogenic carcinoma</i>						<i>2 years</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>pleural effusion</i>						<i>2 months</i>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from April 7, 1966, to Sept. 23, 1966, that I last saw the deceased alive on Sept. 23, 1966, and that death occurred at M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>John C. Stauffer</i>				<b>ADDRESS</b> (Street, city, town, state) <i>M.D. 115 S. Prospect St. Hagerstown, Maryland</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>		<b>DATE THEREOF</b> <i>9/25/66</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>Fairview Cemetery</i>		<b>LOCATION (City, town, or county) (State)</b> <i>Bolivar, West Va.</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>John C. Stauffer</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Donald Eckler</i>		<b>ADDRESS</b> <i>Harpers Ferry, West Va.</i>	
<b>DATE</b> <i>1966</i>							

INSTRUCTIONS

**THE ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom col-7 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M





## CERTIFICATE OF DEATH

13326

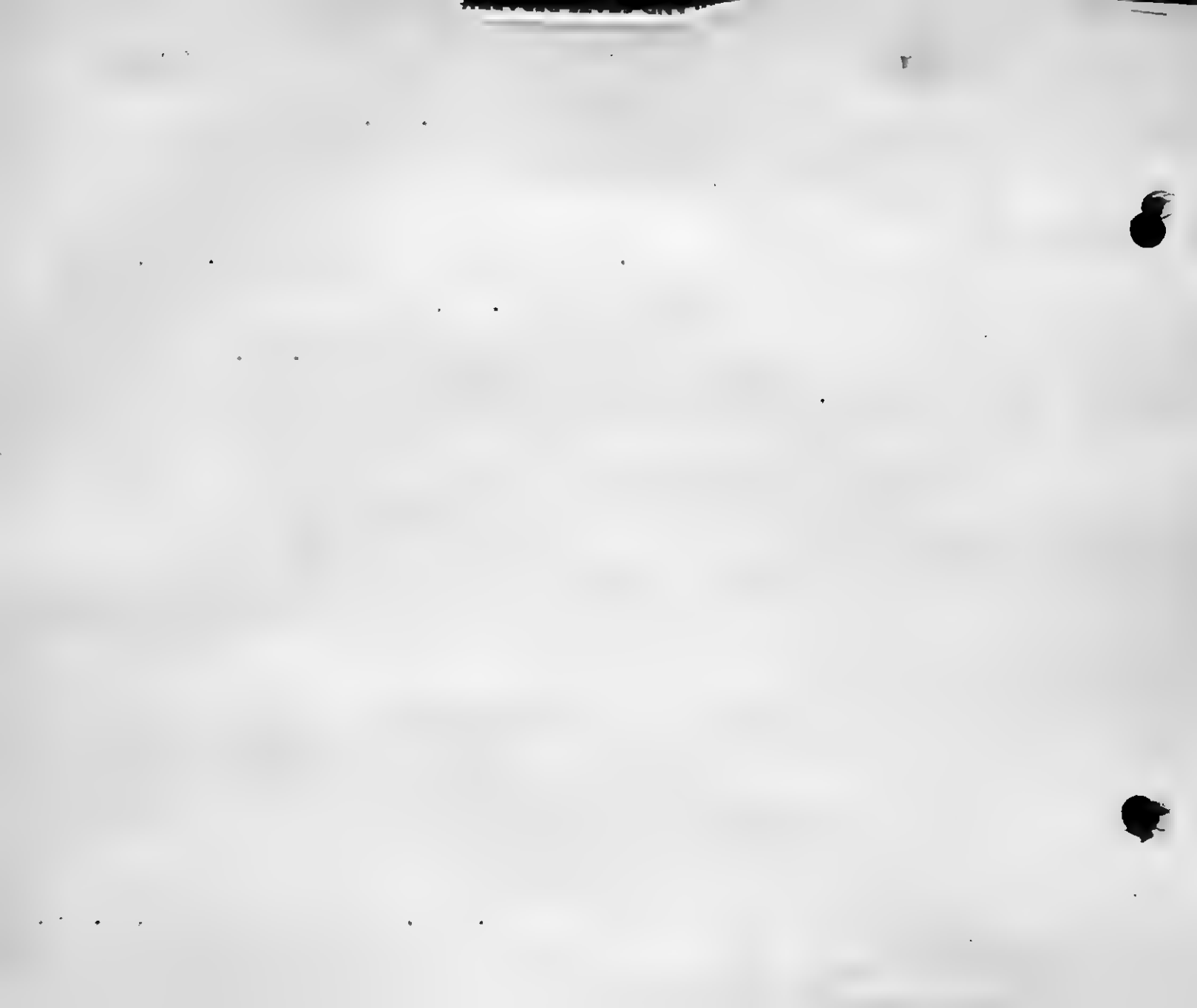
1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>10 hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Co. Hospital</b>		e. STREET ADDRESS <b>Harp Ave.</b>	
3 NAME OF DECEASED (Type or print) First <b>GRACE</b> Middle <b>AMELIA</b> Last <b>HARP</b>		4 DATE OF DEATH Month <b>September</b> Day <b>15</b> Year <b>19 66</b>	
5 SEX <b>female</b>	6 COLOR OR RACE <b>white</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Apr. 15, 1888</b>
9 AGE (In years last birthday) <b>78</b> yrs		10 F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Washington Co. Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>Curtis Gouker</b>		14 MOTHER'S MAIDEN NAME <b>Annie Travers</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO. <b>none</b>	
17 INFORMANT <b>Elmer L. Harp, Myersville, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiac Dis.</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Osteoarthritis</b> <b>Hypertension</b>			
19. WAS A Topsy PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>6 Sept</b> , 19 <b>66</b> , to <b>Date</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>15 Sept 1966</b> , and that death occurred at <b>3P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Richard T. Binford</b>		22b. DATE SIGNED <b>16 Sept 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>RICHARD T. BINFORD, M.D.</b>		22d. ADDRESS <b>135 POTOMAC AVE., HAGERSTOWN, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Sept. 18, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion E.U.B.</b>	23d. LOCATION (City or Town) (County) (State) <b>Myersville Fred. Co. Md.</b>
24. FUNERAL DIRECTOR <b>Paul F. Bittle</b>		25a. REC'D BY REGISTRAR <b>SEP 19 1966</b>	
ADDRESS <b>Paul F. Bittle, Myersville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



VR A15 (4)  
15M 7/61



## CERTIFICATE OF DEATH

13328

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>10 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>2008 Virginia Ave.</u>	
3 NAME OF DECEASED (Type or print) First <u>Elma</u> Middle <u>Margaret</u> Last <u>Hess</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>12</u> Year <u>1966</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Dec. 9, 1877</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (In years last birthday) yrs. <u>88</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Ellitsburg, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Hess</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Jane Baker</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>None</u>	
17 INFORMANT <u>John H. Spangler</u>		Address <u>1103 Oak Hill Ave Hagerstown, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Congestive Heart failure</u> DUE TO (c) <u>Hypertensive cardiovascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 13</u> , 1966, to <u>Sept 12</u> , 1966, that (I) (we) last saw the deceased alive on <u>Sept 12</u> , 1966, and that death occurred at <u>2:30 A.M.</u> from causes and on the date stated above.			
22a SIGNATURE <u>Charles A. Hoffman</u>		22b DATE SIGNED <u>9/12/66</u>	
22c PHYSICIAN'S NAME (Type) <u>Hoyd A. Hoffman</u>		22d ADDRESS <u>214 N. Potomac St Hagerstown, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept 14, 1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Hagerstown, Md.</u>
24 FUNERAL DIRECTOR <u>Charles C. Coffman Funeral Home Inc.</u>		25a REC'D BY REGISTRAR DATE <u>SEP 20 1966</u>	
ADDRESS <u>Hagerstown, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The deceased remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

13329

1 PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 Day</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Boonsboro, Rfd. 2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>			d. STREET ADDRESS <b>Mt. Lena</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last <b>Roy Albert Hoffman</b>			4. DATE OF DEATH Month Day Year <b>September 1, 19 66</b>		
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1913</b>		9. AGE (In years last birthday) <b>53 yrs</b>
10a. US. JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tire Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Mt. Lena, Md.</b>	
13. FATHER'S NAME <b>Albert M. Hoffman</b>			14. MOTHER'S MAIDEN NAME <b>Martha Lum</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>214-09-2389</b>		17. INFORMANT <b>Mrs. Polly I. Hoffman, Rfd. 2, Boonsboro, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute arrhythmia prob neurotic for</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>acute myocardial infarction</b> DUE TO (c) <b>atherosclerotic heart disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>20 hours</b> <b>1 + years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>previous myocardial infarction</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>31 Aug</b> , 19 <b>66</b> , to <b>1 Sept</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>31 Aug</b> , 19 <b>66</b> , and that death occurred at <b>11:45</b> M, from causes and on the date stated above.					
22a. SIGNATURE <b>John C. Stauffer</b>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>9-2-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>John C. Stauffer</b>		22d. ADDRESS <b>145 S. Prospect St., Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-3-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>					
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 6 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	





## CERTIFICATE OF DEATH

13330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 week</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>5 Wood St</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>LARGIE IFENE HOOVER</u>				4 DATE OF DEATH Month Day Year <u>Sept 30 1966 19</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 11 1892</u>	9 AGE (in years last birthday) <u>74 yrs</u>	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of work ing life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Pz Chambersburg Franklin Co</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Shreiner</u>				14. MOTHER'S MAIDEN NAME <u>Eleanora Morett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Miss Eleanor L. Hoover 5 Wood St</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic heart dz</u> DUE TO (c) <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>8 yrs</u> <u>8 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Acute Cholelithiasis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 1926</u> , to <u>Sept. 1966</u> , that (I) (we) last saw the deceased alive on <u>9/25/66</u> , and that death occurred at <u>5:20 PM</u> , from causes and on the date stated above							
22a. SIGNATURE <u>John L. Morten</u>				22b. DATE SIGNED <u>9/30/66</u>		22c. PHYSICIAN'S NAME (Type) <u>John L. Morten</u>	
22d. ADDRESS <u>Hagerstown, Md</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/3/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery Hagerstown Wash. Co. Md</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Hagerstown L.d. Andrew K. Coffman Funeral Home Inc</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



## CERTIFICATE OF DEATH

13331

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>3 Weeks</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		d. STREET ADDRESS <b>600 Preston Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Rev. John Edward Kern Horn</b>		4 DATE OF DEATH Month <b>September</b> Day <b>31</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 24, 1886</b>
9. AGE (In years last birthday) <b>80</b> yrs		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clergymen</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Baltimore City, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Horn</b>		14. MOTHER'S MAIDEN NAME <b>Lizzie Heyn</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>316-46-3757</b>	
17. INFORMANT <b>Mrs Bess Horn</b>		Address <b>600 Preston Road Hagerstown, Maryland</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Adenocarcinoma of Head of Pancreas</b> 157X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9-21-</b> , 19 <b>66</b> , to <b>9-21</b> , 19 <b>66</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>9-21</b> , 19 <b>66</b> , and that death occurred at <b>8 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Dalton M. Welty</b>		22b. DATE SIGNED <b>9/22/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dalton M. Welty, M.D.</b>		22d. ADDRESS <b>998 Potomac Avenue Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Sept. 24, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR <b>Andrew K. Coffman Funeral Home Inc.</b>		25a. REC'D BY REGISTRAR <b>SEP 26 1966</b>	
ADDRESS <b>Hagerstown, Maryland</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

13332

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>10 weeks</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Avalon Manor</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Hagerstown</b>	
3. NAME OF DECEASED (Type or print) <b>ELDEN LOCKWOOD KERNEY</b>		4. DATE OF DEATH <b>Sept. 3 19 66</b>	
5 SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/5/1885</b>
9. AGE (In years last birthday) <b>80</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>3</b> Hours <b>19</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>city clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>city gov.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Shepherdstown, W. Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James W. Kerney</b>		14. MOTHER'S MAIDEN NAME <b>Alice A. Mask</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>214-09-6309</b>	
17. INFORMANT <b>Mrs. T. Aubrey Kemp</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Malignancy of lungs</b> DUE TO <b>poss bronchial cell</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>carcinoma of tongue and bladder</b>			INTERVAL BETWEEN ONSET AND DEATH <b>over 10 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , 19 <b>to death</b> , 19 <b>that (I) (we) later saw the deceased alive on 3 April 1966</b> , and that death occurred at <b>5:25</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>John C. Stouffer</b>		22b. DATE SIGNED <b>9-6-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>John C. Stouffer, M.D.</b>		22d. ADDRESS <b>145 S. Prospect St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>9/7/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR <b>NINNICH FUNERAL HOME Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 13 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13333

1. PLACE OF DEATH a COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Washington</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Knoxville</u>		c LENGTH OF STAY IN 1b <u>years</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 2</u>		d STREET ADDRESS <u>Route 2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Edgar Kidwell</u>		4. DATE OF DEATH Month Day Year <u>9 3 19 66</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/6/1893</u>
9. AGE (In years last birthday) <u>72</u> yrs		10. UNDER 1 YEAR Months Days Hours Min <u>12</u> <u>0</u> <u>0</u> <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>William H. Kidwell</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Phillips</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>W.W.1</u>		16. SOCIAL SECURITY NO <u>705-10-2736</u>	
17. INFORMANT <u>Mrs. Josephine Kidwell, Knoxville, Md</u>		Address <u>Route 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion -</u> DUE TO (b) <u>Arteriosclerotic Heart Disease &amp;</u> DUE TO (c) <u>Diabetes Mellitus</u> Interval between onset and death <u>Immed.</u> <u>20 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>12.11</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Edward W. Ditto III</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DR. E.W.DITTO, III</u> HAG. MD.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>9/4/66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>9/6/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Episcopal Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Brownsville, Wash., Md.</u>	
24. FUNERAL DIRECTOR <u>Gladhill Company, Middletown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 7 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11

11. 17. 1950

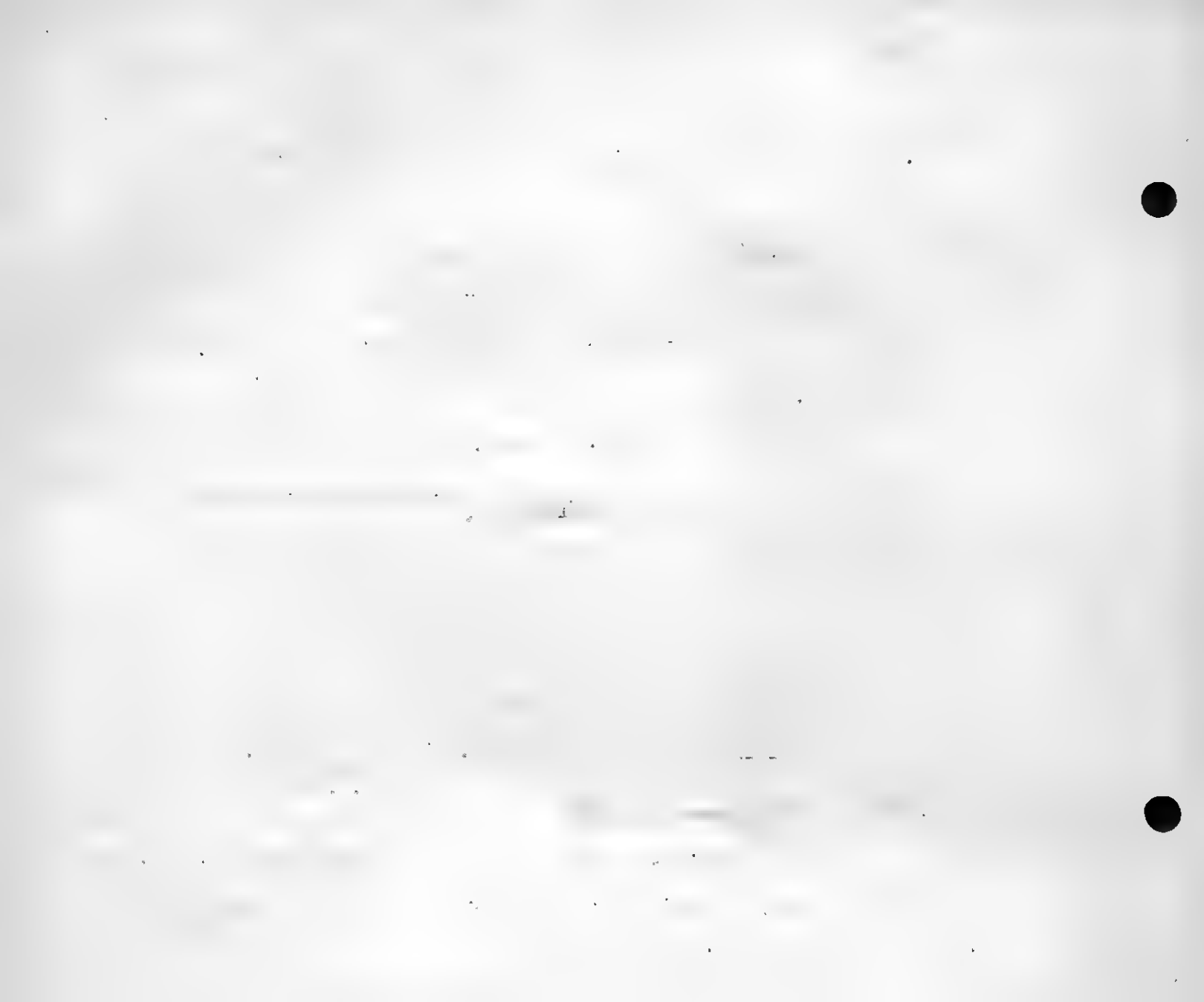


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH					13334				
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>			c. LENGTH OF STAY IN 1b <b>4 YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>112 ELM STREET</b>					d. STREET ADDRESS <b>112 ELM STREET</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FRANKLIN</b>		First <b>FRANKLIN</b> Middle <b>SIMON</b> Last <b>KINDALL</b>		4. DATE OF DEATH <b>SEPTEMBER 13 1966</b>		Month <b>SEPTEMBER</b> Day <b>13</b> Year <b>1966</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 7, 1928</b>		9. AGE (In years last birthday) <b>38</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PARK DEPT.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>CITY HAGERSTOWN</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN L. KINDALL</b>					14. MOTHER'S MAIDEN NAME <b>ELLA M. SWOPE</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>578-34-9810</b>		17. INFORMANT <b>HAGERSTOWN, MARYLAND</b> <b>MRS. HILDA KINDALL 112 ELM STREET</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hodgkin's disease, abdominal with involvement of intestinal tract.</b> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____								INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 10, 1966</b> , to <b>Sept. 13, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept. 12, 1966</b> , and that death occurred at <b>6:00 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <i>William T. Layman, M.D.</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9/14/1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM T. LAYMAN M.D.</b>					22d. ADDRESS <b>PROFESSIONAL ARTS BLDG. HAG. MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>SEPT. 16, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>			23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER HAGERSTOWN, MARYLAND</b>					25a. REC'D BY REGISTRAR <b>SEP 16 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



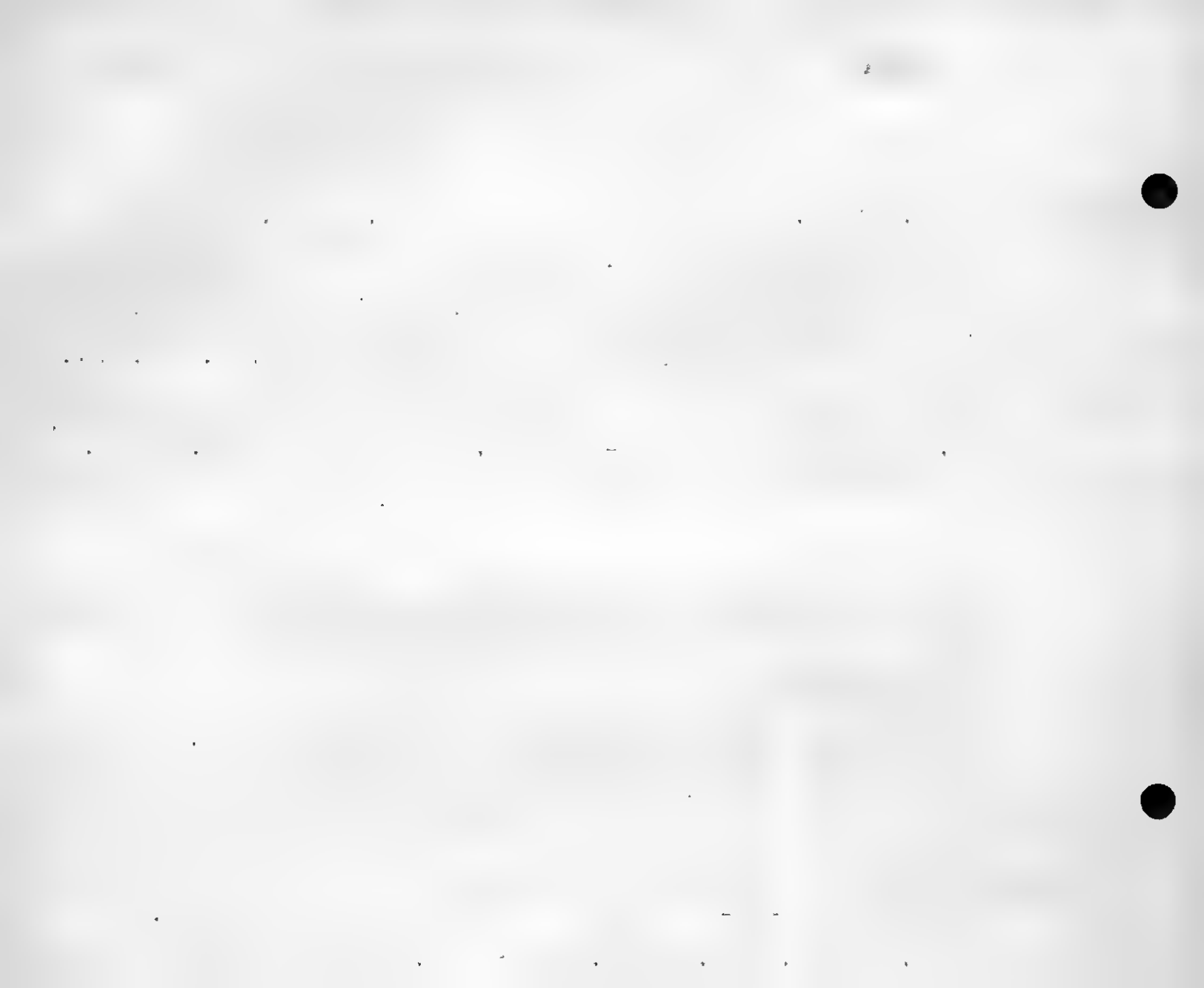
CERTIFICATE OF DEATH

13335

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Keedysville</b> c. LENGTH OF STAY IN 1b <b>10 Years</b>		2 USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Keedysville</b> d. STREET ADDRESS <b>107 N. Main St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Harry C. Kottler</b>		4. DATE OF DEATH Month <b>September</b> Day <b>10</b> Year <b>1966</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 5, 1886</b>
9 AGE (In years last birthday) <b>80</b> yrs		10. IF UNDER 1 Year Months <b>0</b> Days <b>5</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ministry</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Florin Lancaster Oc. Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Micheal Kottler</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Dennis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO <b>218-34-3881</b>	
17. INFORMANT <b>Mrs. Rose K. Kottler, 107 N. Main St.</b>		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>dissecting</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b></b> DUE TO (b) <b></b> DUE TO (c) <b></b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 5, 1966</b> to <b>Sept 10, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 6, 1966</b> , and that death occurred at <b>9 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>G. W. Levan</b>		22b. DATE SIGNED <b>9-12-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. W. Levan</b>		22d. ADDRESS <b>Boonsboro, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9-13-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Boonsboro, Md.</b>
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md</b>		25a. REC'D BY REGISTRAR <b>SEP 15 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
13336									
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>75 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>129 E. LEE ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>LOUISE</b> Last <b>KRETZER</b>			4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>21</b> Year <b>1966</b>						
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/15/1872</b>		9. AGE (in years last birthday) <b>94</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALFRED SMITH</b>					14. MOTHER'S MAIDEN NAME <b>? MOATS</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MR. JOHN L. HENESY</b>		Address <b>HAGERSTOWN MD.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiovascular collapse</b> 4330 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO (c) <b>thrombophlebitis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>1 hr.</b> <b>1 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 6</b> , 19 <b>61</b> to <b>Sept 21</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>Sept 20</b> , 19 <b>66</b> , and that death occurred at <b>11</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Louis Bragg</b>								22b. DATE SIGNED <b>9/25/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Louis Bragg</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <b>350 W. North St. Hagerstown</b>			
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE THEREOF <b>9/24/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>			23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MD.</b>		
24. FUNERAL DIRECTOR <b>W.J. Norment Hagerstown Md.</b>				25a. REC'D BY REGISTRAR <b>SEP 26 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



CERTIFICATE OF DEATH

13332

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or interment, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Boonsboro Rfd. 2</b> c. LENGTH OF STAY IN lb <b>15 Months</b>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fahrney Keedy Memorial Home</b>		d. STREET ADDRESS <b>241 S. Mulberry St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Gamma Lee Krider</b>		4. DATE OF DEATH Month Day Year <b>September 21, 19 66</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>April 4, 1877</b>
9 AGE (In years last birthday) <b>89</b> yrs.		F UNDER 1 YEAR Months Days Hours Min. <b>5 17</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Funkstown, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Krider</b>		14 MOTHER'S MAIDEN NAME <b>Clara Shilling</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>214-09-7441</b>	
17. INFORMANT <b>Miss Anna M. Krider, Boonsboro Rfd. 2, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Adenocarcinoma of the Lung</b> DUE TO (b) <b>Pneumonia</b> DUE TO (c) <b>Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>1 Week</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 20, 1966</b> , to <b>Sept 21, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 20, 1966</b> , and that death occurred at <b>9:15</b> M, from causes and on the date stated above			
22a. SIGNATURE <b>G. W. Lellan</b>		22b. DATE SIGNED <b>9/24/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. W. Lellan</b>		22d. ADDRESS <b>Boonsboro, Md</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-24-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 27 1966</b>	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 7/61



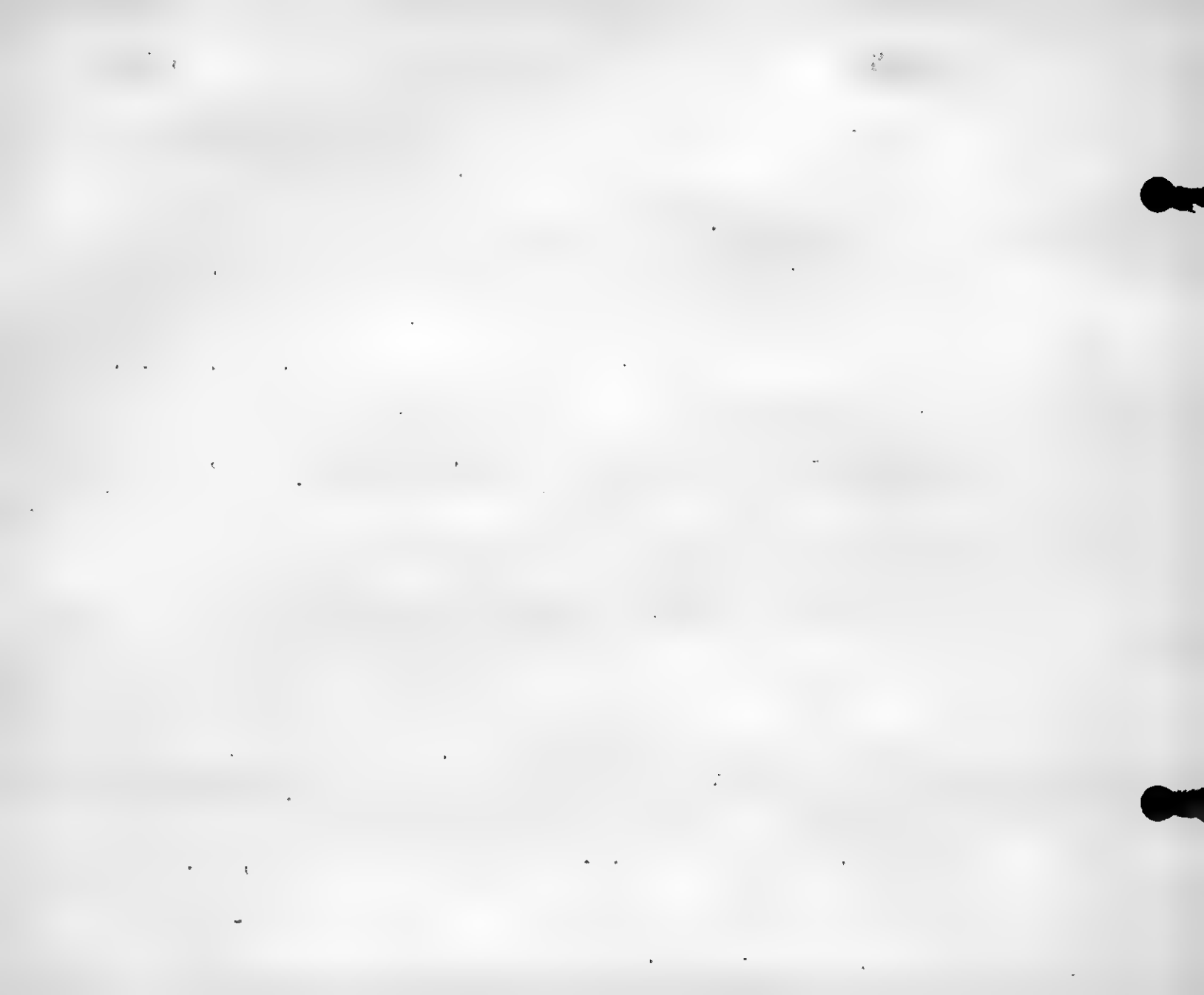
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13338

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> <u>1 DAY</u> c. LENGTH OF STAY IN <u>1 DAY</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. CC. HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>PENNA</u> b. COUNTY <u>FRANKLIN</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GREENCASTLE</u> d. STREET ADDRESS <u>39 LINDEN AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William J. KRINER</u> First Middle Last 4. DATE OF DEATH <u>Sept. 20</u> 19 <u>66</u> Month Day Year		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>9/4/1885</u> 9. AGE (in years last birthday) <u>81</u> yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Franklin Co., Pa.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Andrew KRINER</u> 14. MOTHER'S MAIDEN NAME <u>Alice MYERS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NE</u> 16. SOCIAL SECURITY NO. <u>204-36 5154</u> 17. INFORMANT <u>Dr. Paul Weisselman - Greencastle, Pa.</u> Address <u>RD3</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>arteriosclerotic Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>disease</u> (c) <u>disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (s) <u>5 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour e.m. p.m. Month, Day, Year 19 <u>9/20/66</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1965</u> to <u>9/20/66</u> , that (I) (we) last saw the deceased alive on <u>9/20/66</u> and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>W.C. Brewer</u> M.D. 22b. DATE SIGNED <u>9/21/66</u> 22c. PHYSICIAN'S NAME (Type) <u>W.C. Brewer</u> 22d. ADDRESS <u>Greencastle, Pa.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>9/23/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u> 23d. LOCATION (City, town or county) (State) <u>GREENCASTLE, PA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A.G. Munch</u> ADDRESS <u>Greencastle, Pa.</u> 25a. REC'D BY REGISTRAR <u>SEP 23 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			







CERTIFICATE OF DEATH

13340

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Md. State Hospital</u>		e. STREET ADDRESS <u>Woodbine Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Edward Lee</u>		4. DATE OF DEATH Month <u>9</u> - Day <u>9</u> - Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-26-1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Cemetery Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cemetery</u>	9. AGE (In years last birthday) <u>62</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Wm Lee</u>		14. MOTHER'S MAIDEN NAME <u>Louy Saylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>226-16-2303</u>	
17. INFORMANT <u>MRS. C. Blanche Lee - Woodbine, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>carcinoma of lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>163X</u> (c) <u>unknown</u>			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) <u>this hospital</u> attended the deceased from <u>9-7-1966</u> to <u>9/9</u> , 19 <u>66</u> , that (1) <u>two</u> last saw the deceased alive on <u>9/9/1966</u> , and that death occurred at <u>12:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Victor L. Ramos, M.D.</u>		22b. DATE SIGNED <u>Sept. 9, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Victor Ramos</u>		22d. ADDRESS <u>1500 Penna. Avenue Hagerstown</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-12-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sharon Baptist Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Howard Co. Md.</u>
24. FUNERAL DIRECTOR <u>Harry W. Knight</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 13 1966</u>	
ADDRESS <u>Sylmar, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

13341

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution before admission) a STATE <b>Maryland</b> b COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>84 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Friendship Manor Nursing Home</b>		d. STREET ADDRESS <b>&amp; 739 S. Potomac St.</b>	
3 NAME OF DECEASED (Type or print) <b>GEORGE LUTHER LE FEVRE</b>		4 DATE OF DEATH Month <b>Sept.</b> Day <b>21</b> Year <b>1966</b>	
5 SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Feb. 22, 1882</b>
9 AGE (In years last birthday) <b>84</b> yrs		10 IF UNDER 1 YEAR Months <b>1</b> Days <b>4</b> Hours <b>1</b> Min <b>4</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home building</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William H. LeFevre</b>		14. MOTHER'S MAIDEN NAME <b>Mollie Wallick</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-20-2993</b>	
17 INFORMANT <b>Nora S. LeFevre</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Infarct</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Parkinson's Disease (Senile Type)</b>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 17, 1962</b> to <b>Sept 20, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 20, 1966</b> , and that death occurred at <b>5 a.m.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>B. B. Kneisley</b>		22b. DATE SIGNED <b>9-21-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. B. KNEISLEY</b>		22d. ADDRESS <b>448 W. Washington St. Hagerstown Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>9/23/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR <b>Minnich Funeral Home</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 26 1966</b>	
ADDRESS <b>Hagerstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

13342

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and notify event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eggenstown</u>		c. LENGTH OF STAY IN 1b <u>3 wks</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Waynesboro</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Co. Hospital</u>		d. STREET ADDRESS <u>R. D. 2</u>	
3. NAME OF DECEASED (Type or print) First <u>Marshall</u> Middle <u>L.</u> Last <u>Mentzer</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>30</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1908</u>
9. AGE (In years last birthday) <u>58</u> yrs		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>19</u> Hours <u>66</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Repair</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Black Truck</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Fulton Co., Penna.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Ulysses G. Mentzer</u>	
14. MOTHER'S MAIDEN NAME <u>Alice Gordon</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>176-01-5419</u>		17. INFORMANT <u>Mrs. Marshall L. Mentzer</u> Address <u>Waynesboro #2, Pa.</u>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1st (1902-49) Cerebral Hemiparesis, twice</u> DUE TO (b) <u>160X</u> DUE TO (c) <u>lost.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma Left Kidney Atherosclerotic Heart Disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>7-70</u> , 19 <u>65</u> to <u>Sept 30</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Sept 21</u> , 19 <u>66</u> , and that death occurred at <u>11:30 A.M.</u> , from causes and on the date stated above.	
22a. SIGNATURE <u>E. R. Larchezabal</u>		22b. DATE SIGNED <u>10-1-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. R. Larchezabal</u>		22d. ADDRESS <u>301 W. Preston St., Baltimore, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>Oct. 3, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Greencastle, Franklin, Pa.</u>	
24. FUNERAL DIRECTOR <u>Walter J. Gura</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 5</u> 19 <u>66</u>	
25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>		25c. REGISTRAR'S NAME <u>John J. Judge</u>	



## CERTIFICATE OF DEATH

13343

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 4 weeks		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland		b. COUNTY Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R#3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Friendship Manor Nursing Home						d. STREET ADDRESS Conococheague			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CLARA DELL MILLER						4. DATE OF DEATH Month Day Year September 13 1966					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 8 1879		9. AGE (In years last birthday) 86 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Indian Springs Wash Co			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Isaac Grove						14. MOTHER'S MAIDEN NAME Susan Pine					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Earl S. Miller Hagerstown Md R#3					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u> DUE TO (b) <u>Hypertensive Cardiovascular Dis</u> DUE TO (c) <u>lost.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										INTERVA. BETWEEN ONSET AND DEATH 12 hrs 8 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8-16, 1966, to 9-13, 1966, that (I) (we) lost saw the deceased alive on 9-12, 1966, and that death occurred at 10:00 A.M. from causes on and on the date stated above.											
22a. SIGNATURE Robert P. Conrad						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-14-66	
22c. PHYSICIAN'S NAME (Type) Robert P. Conrad, M.D.						22d. ADDRESS Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/16/66		23c. NAME OF CEMETERY OR CREMATORY St Pauls Cemetery		23d. LOCATION (City or Town) (County) (State) near Claer Spring Wash Co					
24. FUNERAL DIRECTOR Hagerstown Md. Andrew K. Coffman Funeral Home Inc						25a. REC'D BY REGISTRAR DATE SEP 20 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

13344

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 19 Hrs	c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Clear Springs R # 1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS Cress Pond Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last SIMON GEORGE MILLER		4 DATE OF DEATH Month Day Year Sept. 23 1966 19	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 13 1875
9 AGE (In years last birthday) 91 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (County & State, or foreign country) Everett Lenora Co Pa. U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Franklin P. Miller	
14. MOTHER'S MAIDEN NAME Isabelle Barndollar		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 18-74-9295		17. INFORMANT Address Ther R. Miller Cress Pond Rd.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 2:40 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Massive gastro Intestinal Hemorrhage - due Lymphocytic Leukemia & Thrombocytopenia (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) generalized Arteriosclerosis, Severe		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 2, 1966, to Sept 23, 1966, that (I) (we) lost saw the deceased alive on Sept 23, 1966, and that death occurred at 7:15 P.M. from causes and on the date stated above.			
22a. SIGNATURE Edward W. Ditto III, M.D.		22b. DATE SIGNED 9/26/66	
22c. PHYSICIAN'S NAME (Type) Edward W. Ditto III, M.D.		22d. ADDRESS 217 West Washington Street Hag., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/26/66	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md
24. FUNERAL DIRECTOR Name & Address Andrew K. Coffin Funeral Home Inc		25a. REC'D BY REGISTRAR DATE SEP 27 1966	25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
13345									
1. PLACE OF DEATH a. COUNTY Washington					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown					b. COUNTY Washington				
c. LENGTH OF STAY IN 1b 10 Days					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Big Spring, Maryland				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital					d. STREET ADDRESS R.F.D.1				
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last Winfield Albert Mills					4. DATE OF DEATH Month Day Year Sept 9 1966				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 9, 1909		9. AGE (in years last birthday) 56 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Mercersburg, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Albert Mills					14. MOTHER'S MAIDEN NAME Lizie Stoner				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 212-24-5441				
17. INFORMANT Hazel Mills					Address Big Spring, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u> 1538 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									INTERVAL BETWEEN ONSET AND DEATH 4 mos
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 5-16-66, 1966, to 9/9, 1966, that (I) (we) last saw the deceased alive on 9/9, 1966, and that death occurred at 3:55 AM, from the causes and on the date stated above.									
22a. SIGNATURE J. R. Dwyer					22b. DATE SIGNED 9/10/66				
22c. PHYSICIAN'S NAME (Type) J. R. Dwyer					22d. ADDRESS 119 King St Hagerstown Md				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Sept 12, 66		23c. NAME OF CEMETERY OR CREMATORY Clear Spring Mennonite		23d. LOCATION (City, town or county) (State) Clear Spring, Md.		
24. FUNERAL DIRECTOR Donald E. Thompson					25a. REC'D BY REGISTRAR SEP 14 1966				
25b. REGISTRAR'S SIGNATURE Charles Judge									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2c & d Film

CERTIFICATE OF DEATH

13346

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Wash. ✓	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Boonsboro		c LENGTH OF STAY IN 1b 5 years	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fahrney-Keedy Memorial Home		d STREET ADDRESS RFD #2/ 49 E. Franklin St.	
3 NAME OF DECEASED (Type or print) MARY J. MINNICH		4 DATE OF DEATH September 4, 19 66	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 11, 1878
9 AGE (In years lost birthday) yrs 88		IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Luther M. Watkins		14. MOTHER'S MAIDEN NAME Barbara E. Kershner	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO none	
17 INFORMANT Marryatt Watkins, Chicago, Ill		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4 x 100 DUE TO Arrhythmia fibrillation (b) Atherosclerotic heart disease (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH minutes Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 66 to death, 19 66, that (I) (we) last saw the deceased alive on 8-8-66, and that death occurred at 200 P.M. from causes on and on the date stated above.			
22a. SIGNATURE Robert J. Keedy M.D.		22b. DATE SIGNED 9-7-66	
22c. PHYSICIAN'S NAME (Type) ROBERT KEEDY		22d. ADDRESS Hagerstown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-7-66	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or town) (County) (State) Hagerstown, Md.	
24 FUNERAL DIRECTOR ADDRESS Minnich Funeral Home, Hagerstown, Md.		25a REC'D BY REGISTRAR DATE SEP 13 1966	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

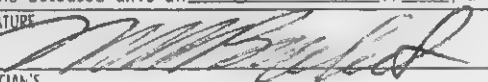



CERTIFICATE OF DEATH

13342

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN lb <b>D. O. A.</b>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Fairplay Rfd. 1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>Tilghmanton</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Mary S. Mongan</b>		4. DATE OF DEATH Month Day Year <b>September 23, 19 66</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>March 10, 1895</b>
9 AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>6 13</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Tilghmanton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Franklin Mongan</b>		14. MOTHER'S MAIDEN NAME <b>Emma Rohrer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Jeremiah Mongan, Fairplay Rfd. 1, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO (b) <b>Atherosclerosis</b> DUE TO (c) <b>None</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>0 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 24, 1958</b> , to <b>Sep 23, 19 66</b> that (I) <del>was</del> last saw the deceased alive on <b>Aug 28, 19 66</b> , and that death occurred at <b>11:00</b> M, from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED <b>Sept 26, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>M. E. Byrkit</b>		22d. ADDRESS <b>Williamsport Maryland 21795</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-27-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Manor Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Tilghmanton, Md.</b>	
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 27 1966</b>	
		25b. REGISTRAR'S SIGNATURE 	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13348

1 PLACE OF DEATH a COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Washington</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d STREET ADDRESS <u>315 Vale St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Solie</u> Middle <u>Martin</u> Last <u>Mongan Sr.</u>		4 DATE OF DEATH Month <u>September</u> Day <u>19</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept. 24, 1905</u>
9 AGE (n years lost birthday) <u>60</u> yrs		10 IF UNDER 1 YEAR Months <u>19</u> Days <u>19</u> Hours <u>66</u> Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Automotor Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cement Mfg.</u>	
11 BIRTHPLACE (State or foreign country) <u>Washington County, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Douglas Mongan</u>		14 MOTHER'S MAIDEN NAME <u>Bessie Host</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>218-01-3028</u>	
17 INFORMANT <u>Mr. Solie Mongan Jr.</u>		Address <u>R # 2 Smithsburg, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>Years</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>Sev. days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Howard N. Weeks, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Howard N. Weeks, M.D.</u>		Address (Street, city, town or county) <u>580 Northern Ave. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/25/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Washington Md</u>
24. FUNERAL DIRECTOR <u>Wm. C. Hunt</u>		25a. REC'D BY REGISTRAR <u>SEP 22 1966</u>	
Address <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a separate certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A SWE (5)  
SM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13349

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland c. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rocky Ridge rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alton Monroe Myers, Jr.		4. DATE OF DEATH Month Sept. 26 Day 19 Year 66	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1948
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	9. AGE (in years last birthday) 18 yrs.
13. FATHER'S NAME Alton M. Myers		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) No		14. MOTHER'S MAIDEN NAME Edith Penwell	
16. SOCIAL SECURITY NO. 212-50-7236		17. INFORMANT Alton M. Myers Rocky Ridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration of Gastric Contents - due</i> DUE TO <i>Laceration of Brain and Blood Vessels</i> (b) <i>cerebral edema and compression</i> (c) <i></i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 1/2 hr.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Nail from Stud gun ricocheted penetrating Brain</i>	
20c. TIME OF INJURY Hour: 9:26 a.m. p.m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Hospital Bldg</i>	20f. (City or town) (County) (State) <i>Frederick Fred. Md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Edmund W. E. H. III</i>		22. DATE SIGNED 9-26-66	
EXAMINER'S NAME (Type) <i>Hagerstown, Md</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-1-66	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	23d. LOCATION (City, town or county) (State) Woodsboro Fred. Co. Md.
24. FUNERAL DIRECTOR <i>Raymond E. Greager</i>		25a. REC'D BY REGISTRAR, 25b. REGISTRAR'S SIGNATURE DATE <i>Oct 3 1966</i> <i>J. J. Jones</i>	





CERTIFICATE OF DEATH

13350

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>6 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>301 S. Mont Valla Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Salvatore</b> Middle <b>N.L.N.</b> Last <b>Nesi</b>		4. DATE OF DEATH Month <b>September</b> Day <b>11</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 24, 1885</b>
9. AGE (in years last birthday) <b>81 yrs</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>00</b> Min <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Lechi, Italy</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Leo Nesi</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Ponzro</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>705-1-1-0010</b>		17. INFORMANT <b>Frank S. Nesi</b> Address <b>303 South Mont Valla Ave Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hypostatic pneumonia</b> 450) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery disease</b> DUE TO (c) <b>Unknown</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 d</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Azotemia, diabetic mellitus</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 3, 1966</b> , to <b>Sept 11, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 11, 1966</b> , and that death occurred at <b>5:20 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>L.L. Packer Jr</b>		22b. DATE SIGNED <b>9/13/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>L.L. Packer Jr</b>		22d. ADDRESS <b>145 W. Washington Hagerstown, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Sept. 14, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Maryland</b>
24. FUNERAL DIRECTOR <b>Andrew K. Coffman Funeral Home Inc.</b>		25a. REC'D BY REGISTRAR <b>SEP 20 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>810 INTERVAL ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>THEODORE</b> Middle <b>W.</b> Last <b>PETERS</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>28</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 11, 1887</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PRODUCE</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-01-8635 A</b>	
17. INFORMANT Address <b>A WELFARE BOARD HAGERSTOWN, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>Syst.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>9/26, 1966</b> , to <b>9/28, 1966</b> , that (I) (we) last saw the deceased alive on <b>9/28 1966</b> , and that death occurred at <b>4:05 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank F. Shupp</b>		22b. DATE SIGNED <b>9/30/1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>FRANK F. SHUPP M.D.</b>		22d. ADDRESS <b>109 1/2 N. POTOMAC ST. HAGERSTOWN, MD.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>10/1/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>	23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN, MARYLAND</b>
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER HAGERSTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>OCT 3 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13352

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>HAGERSTOWN</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>PA.</u> b. COUNTY <u>YORK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>YORK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON COUNTY HOSP. D.O.A.</u>		d. STREET ADDRESS <u>908 CLAYTON AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>DONALD</u> First <u>G.</u> Middle <u>PHILIPS</u> Last	4. DATE OF DEATH Month <u>9</u> Day <u>30</u> Year <u>1966</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-3-1908</u> 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WELDER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>EAST BERLIN, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID</u>		14. MOTHER'S MAIDEN NAME <u>BESSIE MCINTIRE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>175-10-0390</u>	
17. INFORMANT <u>ESTELLA S. PHILIPS</u>		Address <u>908 CLAYTON AVE. YORK PA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>occlusion Right coronary Artery =</u> DUE TO <u>Marked hypertrophy + Dilatation of</u> (b) <u>Right + Left ventricle - Due</u> DUE TO <u>Advanced Arteriosclerotic Heart</u> (c) <u>Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 Hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Edward W. Ditto, III</u>		M.O. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Edward W. Ditto, III, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		22. DATE SIGNED <u>10-1-66</u>	
		Address (Street, city, town, or county) <u>Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10-3-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MUNIMERTS CEM.</u>	23d. LOCATION (City, town or county) (State) <u>ADAMS PA.</u>
24. FUNERAL DIRECTOR <u>Wm. R. Dodson Jr.</u>		ADDRESS <u>517 N. GEORGE ST. YORK PA.</u>	
25a. REC'D BY REGISTRAR DATE <u>OCT 1 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1099

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13353

1. PLACE OF DEATH a. COUNTY <i>Washington</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i> c. LENGTH OF STAY IN 1b <i>15 yrs.</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Western Maryland State Hospital</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Washington</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural Hagerstown, Md. R.R.#6</i> d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Jean Livingston Pinney</i>		4. DATE OF DEATH Month Day Year <i>9-24 1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-2-97</i>
9. AGE (in years last birthday) <i>69</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <i>69</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Frostburg Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Frank Whetstone</i>		14. MOTHER'S MAIDEN NAME <i>Mollie Street</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-09-1923</i>	
17. INFORMANT <i>Chauncey S. Pinney</i>		Address <i>Hagerstown, Md. R.R.#6</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis</i> <i>110X</i> DUE TO (b) <i>Carcinoma of Breast</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <i>8 yrs.</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>6-2-1966</i> to <i>9-24-1966</i> that (I) (we) last saw the deceased alive on <i>9-24-1966</i> , and that death occurred at <i>9:30</i> M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Frank Riego</i>		22b. DATE SIGNED <i>9-24-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>FRANK RIEGO</i>		22d. ADDRESS <i>1500 Penna. Ave., Hagerstown</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9/27/66</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Hagerstown, Md.</i>	
24. FUNERAL DIRECTOR <i>Wm. G. Hoot</i>		25a. REC'D BY REGISTRAR <i>SEP 27 1966</i>	
Address <i>Rest Haven Funeral Chapel Inc. Hagerstown, Md</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

13

E. 1. - 90-212



CERTIFICATE OF DEATH

13351

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>205 Division Ave.</b>	
3 NAME OF DECEASED (Type or print) <b>Baby Boy Rich</b>		4 DATE OF DEATH Month <b>Sept.</b> Day <b>25</b> Year <b>1966</b>	
5 SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 25, 1966</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs <b>6</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Thomas M. Rich</b>		14. MOTHER'S MAIDEN NAME <b>Jo Ann Kester</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Thomas M1 Rich, Hagerstown, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mosses atelectasis</b> DUE TO <b>Pneumonia, (1 lb 15 oz)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9/25/66</b> to <b>9/25/66</b> , that (I) (we) last saw the deceased alive on <b>9/25/1966</b> , and that death occurred at <b>11:45 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>A. M. Bacon, Jr.</b>		22b. DATE SIGNED <b>9/30/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. M. Bacon, Jr. M.D.</b>		22d. ADDRESS <b>101 Ring Street Hagerstown Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>9-26-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or town) (County) (State) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 27 1966</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>J. L. Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

13355

1 PLACE OF DEATH a. COUNTY <u>Shirlington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE <u>Penn.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 Mo.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shirlington County Hospital</u>		e. STREET ADDRESS <u>Greencastle R # 1</u>	
3 NAME OF DECEASED (Type or print) <u>CENEVIEWE MARY RZOMP</u>		4. DATE OF DEATH <u>September 19 1966</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7 1913</u>
9 AGE (In years last birthday) <u>47</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Brenizer Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stanley Ololakowski</u>		14. MOTHER'S MAIDEN NAME <u>Stella Wisniewski</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>178-20-0201</u>	
17. INFORMANT <u>Casimir H. RZOMP</u>		Address <u>Greencastle Pa</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> <u>151X</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 9, 1966</u> , to <u>Sept 19, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 19, 1966</u> , and that death occurred at <u>4:30 AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>John A. Moran</u>		22b. DATE SIGNED <u>Sept 19, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>John A. Moran</u>		22d. ADDRESS <u>215 W. Washington St Hagerstown Md</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/22/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>C.S. Simon &amp; Sons</u>	23d. LOCATION (City or Town) (County) (State) <u>Blairsville Indiana Pa</u>
24. FUNERAL DIRECTOR <u>Andrew W. Corbin Funeral Home Inc</u>		25a. REC'D BY REGISTRAR <u>SEP 21 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

13356

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Hagerstown</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>2428 Jefferson Blvd.</b>	
3. NAME OF DECEASED (Type or print) <b>THELMA ELIZABETH SENSENBAUGH</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>2</b> Year <b>1966</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 5, 1911</b>
9. AGE (In years last birthday) <b>55</b> yrs		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>public school</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Smithsburg, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>George E. Winders</b>	
14. MOTHER'S MAIDEN NAME <b>Anna M. Shank</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>219-36-3807</b>		17. INFORMANT <b>Glenn Sensenbaugh</b> Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Documented blood carcinoma of the abdomen</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: _____		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetic bronchitis, Chronic</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 14</b> , 19 <b>50</b> to <b>Sept 2</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Sept 2</b> , 19 <b>66</b> , and that death occurred at <b>8:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Philip J. Hirshman</b>		22b. DATESIGNED <b>9/3/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>		22d. ADDRESS <b>159 W. Washington St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>9/5/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR <b>MINNICH FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>SEP 7 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, at any event, within 72 hours after death.



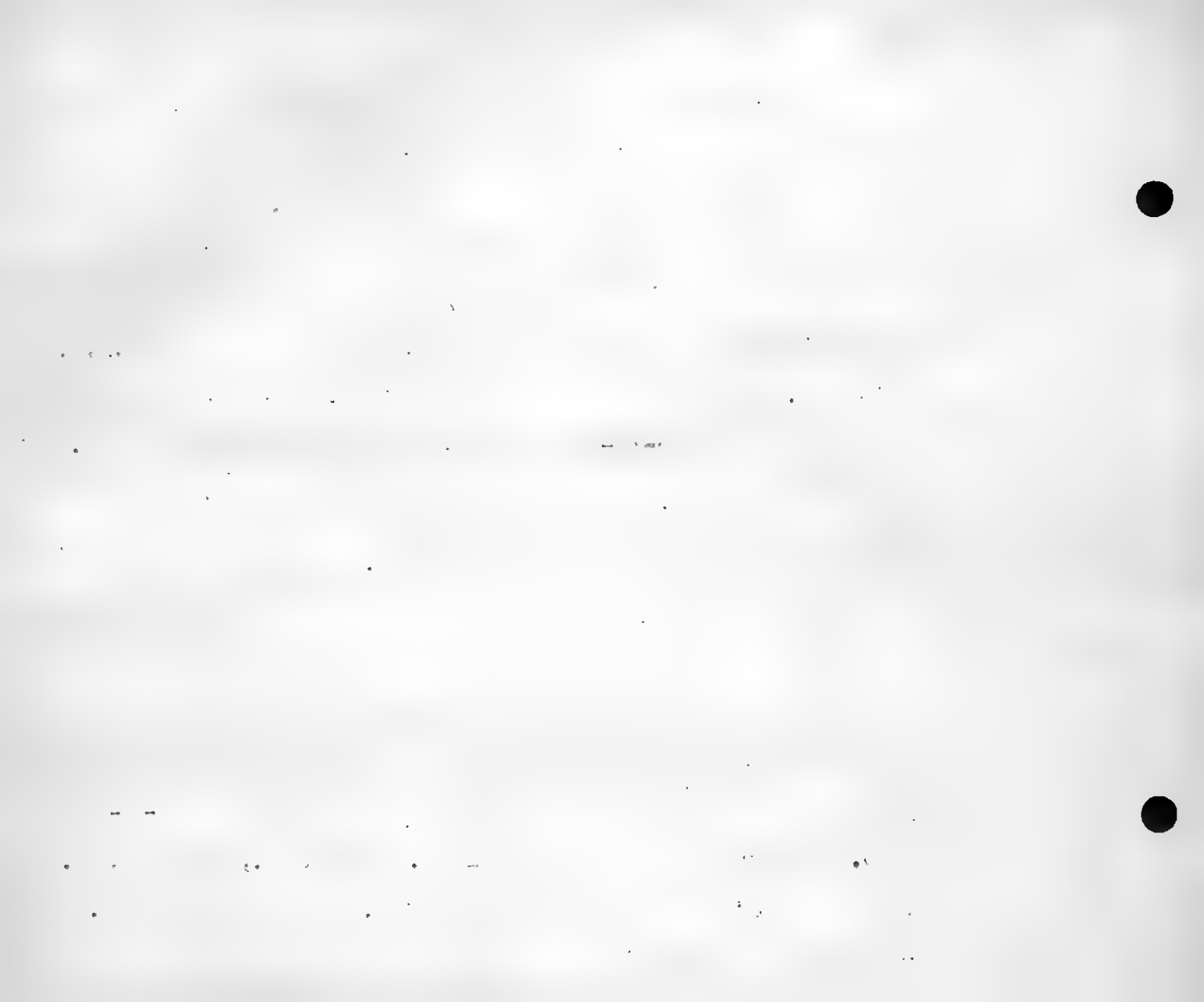
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ZDM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13357

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>12 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>64 NORTH AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROSS</b> Middle <b>DALE</b> Last <b>SHINDLE</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>24</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/14/1909</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED STOCKMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RAIL ROAD</b>	9. AGE (In years last birthday) <b>56</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM E. SHINDLE</b>		14. MOTHER'S MAIDEN NAME <b>ALICE EICHELBERGER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>705-10-5439</b>	
17. INFORMANT <b>MRS. LAURA B. SHINDLE</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>rupture of intraventricular septum</b> DUE TO (b) <b>myocardial infarction</b> DUE TO (c) <b>arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>paralysis agitans</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 da; 4 weeks</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>9/3, 1966</b> , to <b>Sept 24, 1966</b> , that (I) (we) last saw the deceased alive on <b>24 Sept 19 66</b> , and that death occurred at <b>4:20 PM</b> , from the causes and on the date stated above.	
22a. SIGNATURE <b>John C. Stauffer</b>		22b. DATE SIGNED <b>9-26-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>John C. Stauffer</b>		22d. ADDRESS <b>1145 S. Prospect St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9/27/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BEAUTIFUL VIEW CEM.</b>		23d. LOCATION (City, town or county) (State) <b>STATE LINE MD.</b>	
24. FUNERAL DIRECTOR <b>W. J. Korman, Hagerstown Md</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE		DATE <b>SEP 20 1966</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

1 (M)  
4  
7

13352

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SMITHSBURG</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SMITHSBURG</b>			
c. LENGTH OF STAY IN 1b <b>10 YR</b>				d. STREET ADDRESS <b>39 E. WATER ST.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>39 E. WATER ST.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>BRUCE HARRY SHOCKEY</b>				4. DATE OF DEATH Month Day Year <b>SEPT. 1 1966</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 19, 1914</b>	
9. AGE (In years last birthday) <b>51 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICIAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>ELECTRICAL</b>		11. BIRTHPLACE (County & State, or foreign country) <b>ROBERTSVILLE, PA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>BRUCE SHOCKEY</b>				14. MOTHER'S MAIDEN NAME <b>NETTIE MCCARNEY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>173-03-3580</b>		17. INFORMANT <b>ELAINE SHOCKEY</b> Address <b>SMITHSBURG, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO (b) <b>Coronary Atherosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b> <b>7 yrs</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1, 1966</b> to <b>Sept 1, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 1, 1966</b> , and that death occurred at <b>1:30 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>G. A. Kohler</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>G. A. KOHLER</b>				22b. DATE SIGNED <b>Sept 1, 1966</b>		22d. ADDRESS <b>Smithsburg, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9/3/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREEN HILL</b>		23d. LOCATION (City, town, or county) (State) <b>WAYNESBORO, PA.</b>	
24. FUNERAL DIRECTOR <b>W. T. Norment</b> Address <b>Hog, Md.</b>				25a. REC'D BY REGISTRAR <b>SEP 6 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

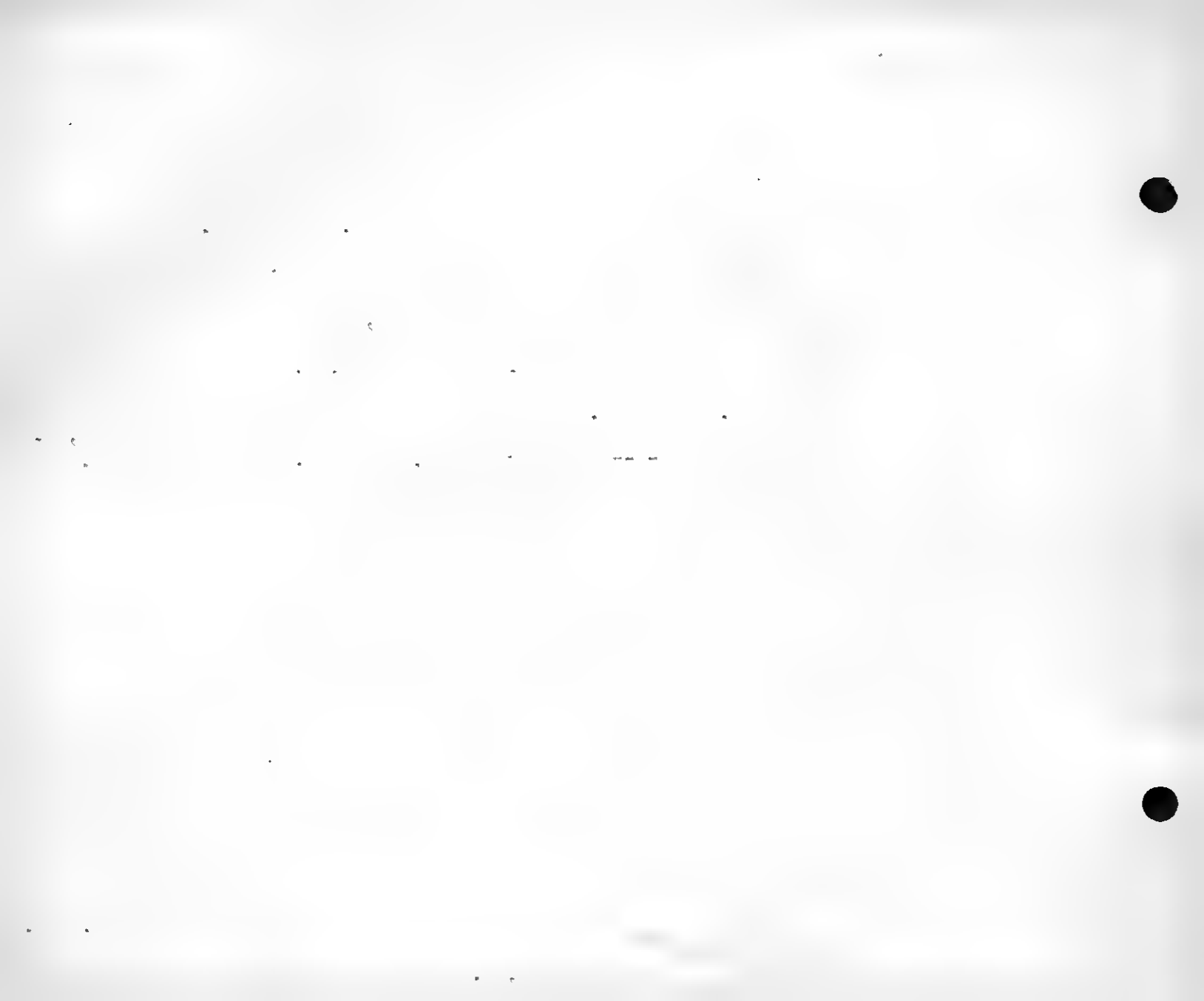
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13359

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if not in residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c LENGTH OF STAY in 1b <u>Life</u>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d STREET ADDRESS <u>25 1/2 W. Franklin St.</u>	
3 NAME OF DECEASED (Type or print) First <u>Floyd</u> Middle <u>Leon</u> Last <u>Sisler</u>		4. DATE OF DEATH Month <u>September</u> Day <u>18</u> Year <u>19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 13, 1949</u>
9 AGE (In years last birthday) <u>17</u> yrs		10 UNDER 1 YEAR Months <u>1</u> Days <u>19</u> Hours <u>66</u> Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Form Setter</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Concrete Pipe Mfg.</u>	
11 BIRTHPLACE (State or foreign country) <u>Keedysville, Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Francis E. Sisler Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Mildred May Wolfe</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-50-9986</u>	
17 INFORMANT <u>Francis E. Sisler Sr.</u>		Address <u>Hagerstown, Md.</u> <u>1020 1/2 Corbett St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Brain stem injury (lac.)</u> DUE TO (b) <u>trauma</u> DUE TO (c) <u>sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hours</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRINCIPAL OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Pt. was thrown from car in a collision, Rt. 11, Marlowe, W. Va.</u>	
20c TIME OF INJURY Month, Day, Year Hour <u>11:30</u> pm <u>9/17</u> 19 <u>66</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> a work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>
20f (City or town) <u>Marlowe, W. Va.</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Howard N. Weeks</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Howard N. Weeks, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		580 Northern Ave. Hagerstown, Md.	
23a BURIAL, CREMATION, REMOVAL <u>Burial</u>		23b DATE THEREOF <u>9/22/66</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown</u> <u>Wash.</u> <u>Md.</u>	
24 FUNERAL DIRECTOR <u>Wm. G. Horn</u>		ADDRESS <u>Rest Haven Funeral Chapel, Hagerstown, Md.</u>	
25a REC'D BY REGISTRAR DATE <u>SEP 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



CERTIFICATE OF DEATH

13360

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>8 MOS. 12 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WESTERN MARYLAND HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL, HAGERSTOWN</b> d. STREET ADDRESS <b>R.D.# 2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Nannie MAE Skelton</b>		4. DATE OF DEATH Month <b>9</b> Day <b>10</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4-24-01</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>9</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILBUR SKELTON</b>		14. MOTHER'S MAIDEN NAME <b>MARY BELLE DAVIS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>HAGERSTOWN, MARYLAND</b> <b>MR. LEONARD SHOEMAKER 145 N. AVENUE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Lobular Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Cerebral Thrombosis</b> (b) (c) DUE TO DUE TO DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>9 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2-28, 1966</b> to <b>9-10, 1966</b> that (I) (we) last saw the deceased alive on <b>9-10 1966</b> and that death occurred at <b>4:45 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Arturo Riego</b>		22b. DATE SIGNED <b>9/10/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Arturo RIEGO</b>		22d. ADDRESS <b>1500 Penn. Ave, Hagerstown</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>9/13/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR LAWN CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN MARYLAND</b>
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER</b>		25a. REC'D BY REGISTRAR <b>SEP 15 1966</b>	
ADDRESS <b>HAGERSTOWN, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



CERTIFICATE OF DEATH

13361

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institut on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>6 Hr.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. STREET ADDRESS <b>Cress Pond Road</b>	
3 NAME OF DECEASED (Type or print) <b>Lisa Marie Smith</b>		4 DATE OF DEATH Month <b>Sept</b> Day <b>16</b> Year <b>1966</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Sept. 16, 1966</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	9 AGE (In years last birthday) yrs <b>6</b> IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS
11 BIRTHPLACE (County & State or foreign country) <b>Hagerstown, Md.</b>		12 CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13 FATHER'S NAME <b>Robert L Smith</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Feigley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give name and dates of service) <b>No</b>		16 SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Robert L Smith</b>		Address <b>Cress Pond Road Clearspring, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congenital abnormality of diaphragm with herniation of abdominal contents into left thorax with resultant atelectasis of lung.</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>of lung.</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9/16/66</b> 19 to <b>9/16/66</b> 19, that (I) (we) last saw the deceased alive on <b>9/16/66</b> 19, and that death occurred at <b>4:30 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Howard N. Weeks</i>		22b. DATE SIGNED <b>9/17/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M.D.</b>		22d. ADDRESS <b>580 Northern Ave. Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Sept. 19, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Md. Wash Co</b>
24 FUNERAL DIRECTOR <b>Andrew A. Coffman Funeral Home Inc.</b>		25a. REC'D BY REGISTRAR <b>SEP 21 1966</b>	
ADDRESS <b>Hagerstown, Maryland.</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





## CERTIFICATE OF DEATH

13362

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or other disposition, and in any event, within 72 hours after death.

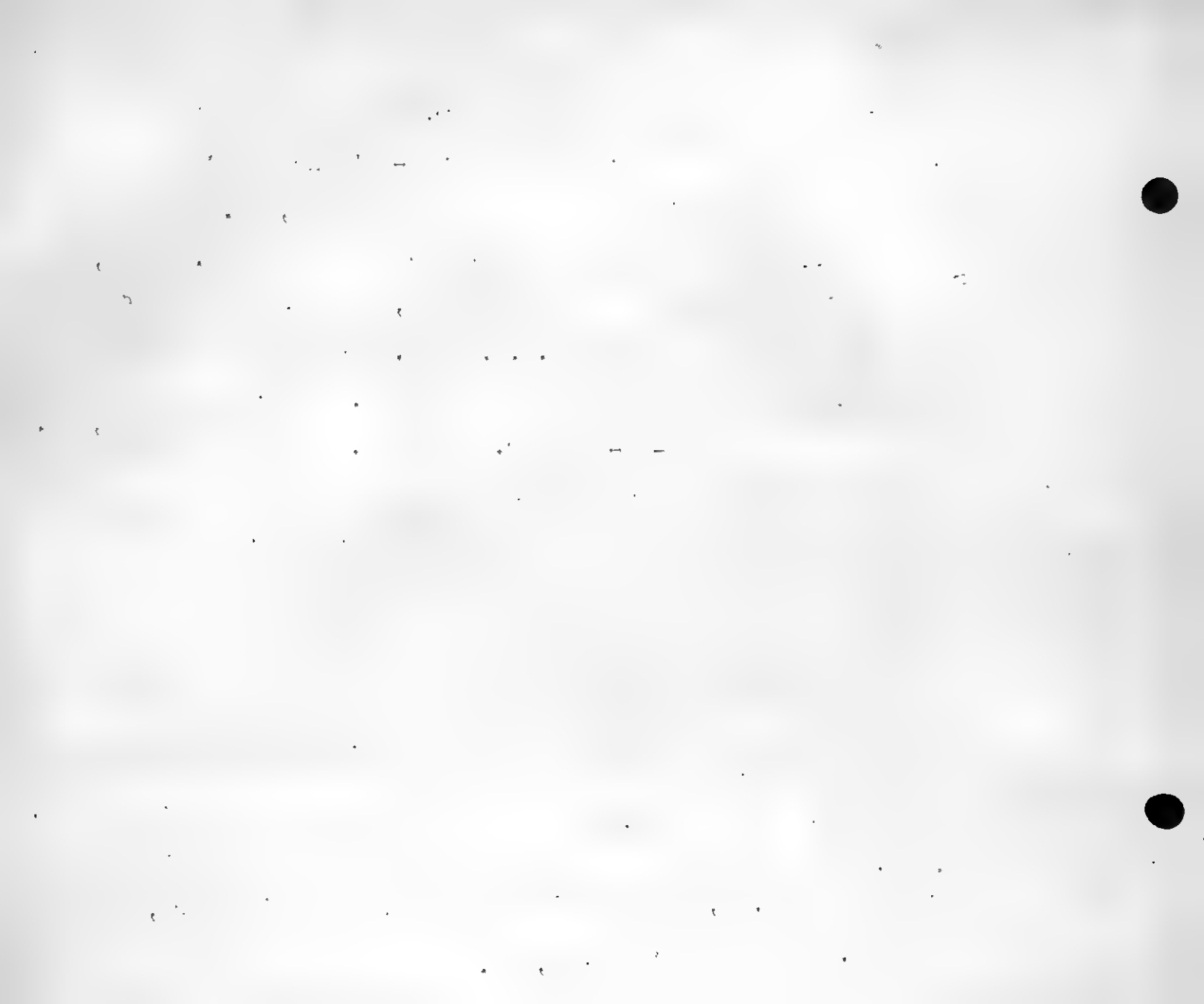
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>56 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Coffman Home for the Aging</b>		e. STREET ADDRESS <b>810 Potomac Avenue</b> <b>Coffman Home for the Aging</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ELIZABETH</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>10,</b> Year <b>19 66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 16, 1874</b>
9. AGE (In years last birthday) <b>92 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Ignatus H. Kimmelman</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Pfaff</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-8062</b>	
17. INFORMANT <b>J. Paul Smith, Hagerstown, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>44 IX</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <b>Hypertensive Vasc. Disease</b> DUE TO (c) <b>Arteriosclerosis - Generalized</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b> <b>18 yrs</b> <b>15 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>Dr. (this hospital)</b> attended the deceased from <b>Feb</b> , 1948, to <b>Sept 10, 1966</b> , that (1) <b>(no)</b> last saw the deceased alive on <b>Sept 10</b> - 1966, and that death occurred at <b>5:15 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Charles A. Hoffmann</b>		22b. DATE SIGNED <b>9/11/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Walter A. Hoffmann</b>		22d. ADDRESS <b>214 N. Potomac St.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>9-12-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Mem. Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 13 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH** 13363

<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> Washington MARYLAND <b>b. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town) Hagerstown <b>c. LENGTH OF STAY IN 1b</b> 2 weeks <b>d. NAME OF HOSPITAL OR INSTITUTION</b> (if not in hospital, give street address) Washington County Hospital				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) <b>a. STATE</b> Maryland <b>b. COUNTY</b> Washington <b>c. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town) RURAL- Williamsport <b>d. STREET ADDRESS</b> Williamsport, Md. RFD #2 <b>e. IS RESIDENCE ON A FARM?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last RALPH MAXWELL SNYDER <b>4. DATE OF DEATH</b> Sept. 10, 1966				<b>5. SEX</b> Male <b>6. COLOR OR RACE</b> White <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> June 25, 1906 <b>9. AGE</b> (In years last birthday) 60 yrs. <b>IF UNDER 1 YEAR</b> Months 3 Days 18 <b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Brakeman <b>10b. KIND OF BUSINESS OR INDUSTRY</b> Western Md. R.R. <b>11. BIRTHPLACE</b> (County & State, or foreign country) Wash. Maryland <b>12. CITIZEN OF WHAT COUNTRY?</b> USA				<b>13. FATHER'S NAME</b> Isaac Snyder <b>14. MOTHER'S MAIDEN NAME</b> Maude E. Renner			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) No <b>16. SOCIAL SECURITY NO.</b> 215-01-9837 <b>17. INFORMANT</b> Mr. Joseph M. Snyder Address: Pinesburg, Md. Williamsport RFD 2				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute liver failure (b) Carcinoma of liver (anaplastic) (c) Secondary Cirrhosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				<b>21. I certify that (I) (this hospital) attended the deceased from 8-31, 1966, to 9-10, 1966, that (I) (we) last saw the deceased alive on 9-9, 1966, and that death occurred at 11:50 AM, from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> G. M. Mandell <b>22b. DATE SIGNED</b> 9-10-66 <b>22c. PHYSICIAN'S NAME (Type)</b> G. M. MANDELL M.D. <b>22d. ADDRESS</b> 119 E. ANTIETAM ST. H.A.C.			
<b>23a. BURIAL, CREMATION, or other disposition</b> (Specify) Burial <b>23b. DATE THEREOF</b> Sept. 12, 1966 <b>23c. NAME OF CEMETERY OR CREMATORY</b> Greenlawn Cemetery <b>23d. LOCATION (City, town or county) (State)</b> Williamsport, Maryland				<b>24. FUNERAL DIRECTOR</b> ADDRESS Albert L. Leaf Williamsport, Md. <b>25a. REC'D BY REGISTRAR</b> DATE SEP 13 1966 <b>25b. REGISTRAR'S SIGNATURE</b> J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

13364

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before adm. sign) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Columbia Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Western Maryland State</b>		d. STREET ADDRESS <b>7612 Ridge Drive</b>	
3 NAME OF DECEASED (Type or print) <b>Thomas Howard Snyder</b>		4 DATE OF DEATH <b>Sept. 5, 1966</b>	
5 SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 2, 1911</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painter</b>	9. AGE (In years, lost birthday) vs. <b>55</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas J. Snyder</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Wilson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>412-16-9295</b>	
17. INFORMANT <b>June C. Funk- 7627 Greenleaf Road</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a)		<b>Lobular pneumonia</b>	
DUE TO		<b>cerebral thrombosis</b>	
(b)		<b>Hypertension</b>	
DUE TO		<b>unknown</b>	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>(1) Arteriosclerotic heart disease (2) Septicemia</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) <del>this hospital</del> attended the deceased from <b>April 26, 1966</b> , to <b>Sept. 5, 1966</b> , that (1) <del>was</del> lost saw the deceased alive on <b>Sept. 5, 1966</b> , and that death occurred at <b>7:59 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Victor L. Ramos, M.D.</b>		22b. DATE SIGNED <b>Sept. 5, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>VICTOR L. RAMOS, M.D.</b>		22d. ADDRESS <b>Western Md. State Hospital Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>Sept 7, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Macedonia</b>		23d. LOCATION (City or Town) (County) (State) <b>Frederick Co. Va.</b>	
24. FUNERAL DIRECTOR <b>Harold M. Rogant - Winchester Va.</b>		25a. REC'D BY REGISTRAR <b>SEP 9 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

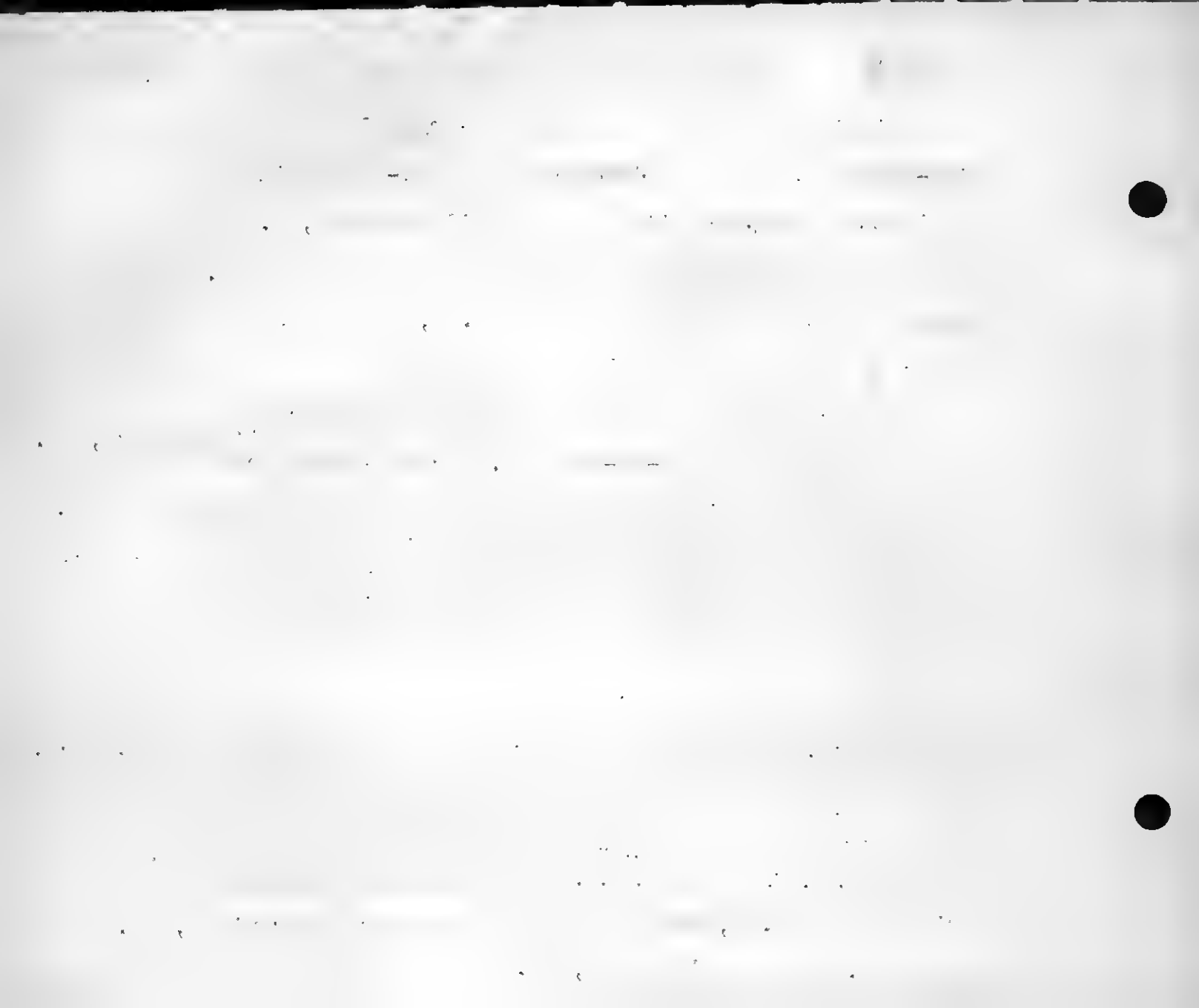
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13365

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>One month</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. STREET ADDRESS <b>Williamsport, Md. RFD #1</b>	
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>WOLFORD</b> Last <b>SOCKS</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>7</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
9. AGE (In years last birthday) <b>65 yrs.</b>		10. DATE OF BIRTH <b>Oct. 2, 1900</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Earl Moats</b>		14. MOTHER'S MAIDEN NAME <b>Annie Wolford</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-14-6054</b>	
17. INFORMANT <b>Mr. Charles Edgar Socks</b>		Address <b>Williamsport, Md. RFD #1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURE OF LEFT VENTRICLE WITH CARDIAC TAMPONADE</b> DUE TO <b>MYOCARDIAL INFARCTION, ANTERIOR APICAL REGION,</b> (b) <b>FRESH -- THROMBOTIC OCCLUSION OF ANTERIOR DESCENDING LEFT CORONARY ARTERY (RECENT WITH FRESH</b> DUE TO <b>PROPAGATION) FRACTURED FEMUR</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>5 HRS.</b> <b>Recent</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>FELL IN HOME</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>4:20 p.m.</b> Aug. <b>10</b> 19 <b>66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>WILLIAMSPORT WASH. MD.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>[Signature]</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>DR. E. W. DITTO, JR. M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		22. DATE SIGNED <b>SEPT. 8, 1966</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 10, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bakersville Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Bakersville, Md.</b>	
24. FUNERAL DIRECTOR <b>Albert L. Leaf</b>		25a. REC'D BY REGISTRAR, 25b. REGISTRAR'S SIGNATURE <b>SEP 13 1966</b> <i>[Signature]</i>	
ADDRESS <b>Williamsport, Md.</b>		DATE	





FOR STATE  
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13366

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. LENGTH OF STAY IN Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Big Spring, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Williamsport Maryland		d. STREET ADDRESS R.F.D. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harold		First Gene		Middle Stevens	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Dec. 23, 1937		9. AGE (in years) 28 yrs		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Brick Yard		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Lauren Stevens		14. MOTHER'S MAIDEN NAME Louise Shaw	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 219-34-7369		17. INFORMANT Patricia Stevens	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 719.8 DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		Gunshot wound of chest		INTERVAL BETWEEN ONSET AND DEATH 10 Min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20b. while removing 0.22 rifle from auto, man pulled trigger - firing gun - Bullet struck Mr. Stevens 100 yds away.					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter notice of injury in Part I or Part II of item 18) While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Factory	
20c. TIME OF INJURY Month, Day, Year 9:50 pm Sept 3, 1966		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (City or town) (County) (State) Williamsport Wash Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Edward W. Ditto III, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 9-3-66	
EXAMINER'S NAME (Type) Edward W. Ditto III, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Hag., Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 5, 66		23c. NAME OF CEMETERY OR CREMATORY Shanktown	
24. FUNERAL DIRECTOR Donald E. Thompson		ADDRESS Clear Spring Md.		25a. REC'D BY REGISTRAR SEP 8 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If July delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
13367									
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>5 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>209 MEALEY PKWY.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>HOWARD</b> Middle <b>KIEFFER</b> Last <b>STICKELL</b>			4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>15</b> Year <b>19 66</b>						
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 25, 1884</b>		9. AGE (In years last birthday) <b>81</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED OFFICIAL</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>GRAIN MILL</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>DANIEL A. STICKELL</b>					14. MOTHER'S MAIDEN NAME <b>LAURA MIDDLEKAUFF</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>214-09-6372</b>		17. INFORMANT <b>HAGERSTOWN, MARYLAND</b> <b>MARGARET STICKELL 209 MEALEY PKWY.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b> <b>1115</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Squamous cell carcinoma of face</b> DUE TO (c) <b>2 1/2 yrs</b>								INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>AUG.</b> , 19 <b>66</b> , to <b>SEPT. 15</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>SEPT. 15</b> , 19 <b>66</b> , and that death occurred at <b>5 P.</b> M. from the causes and on the date stated above.									
22a. SIGNATURE <b>Lloyd A. Hoffman</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9/16/1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>LLOYD A. HOFFMAN M.D.</b>					22d. ADDRESS <b>214 N. POTOMAC ST. HAGERSTOWN, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9/19/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>			23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN, MARYLAND</b>		
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER</b> <b>HAGERSTOWN, MARYLAND</b>					25a. REC'D BY REGISTRAR <b>SEP 21 1966</b> DATE 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 11, MARYLAND  
15306  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>W. VIRGINIA</b> b. COUNTY <b>BERKLEY</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>5 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>426 SUMMIT AVENUE</b>		d. STREET ADDRESS <b>R.D.# 1</b>	
3. NAME OF DECEASED (Type or print) First <b>RUTH</b> Middle <b>BAIRD</b> Last <b>STONE</b>		4. DATE OF DEATH Month <b>SEPT.</b> Day <b>1</b> Year <b>19 66</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 11, 1897</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	9. AGE (in years last birthday) <b>69 yrs.</b>
11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN RHODES</b>		14. MOTHER'S MAIDEN NAME <b>FLORENCE HEMPHILL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-14-6165</b>	
17. INFORMANT <b>HAGERSTOWN, MD.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) <b>Atherosclerotic Heart Disease</b> DUE TO (c) <b>Essential Hypertension</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs</b> <b>2 yrs</b> <b>4 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/23</b> , 19 <b>65</b> to <b>9/1</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7/19</b> , 19 <b>66</b> , and that death occurred at <b>270</b> AM, from the causes and on the date stated above.			
22a. SIGNATURE <b>Donald E. Martin</b>		22b. DATE SIGNED <b>9/2/1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>DONALD E. MARTIN M.D.</b>		22d. ADDRESS <b>418 N. POTOMAC ST. HAGERSTOWN, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>9/3/1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEMETERY</b>	23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN, MARYLAND</b>
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER HAGERSTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>SEP 6 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN ID <b>2 MONTHS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>1034 HAMILTON BLVD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MADELINE REYNOLDS STOUFFER</b>		4. DATE OF DEATH <b>SEPTEMBER 10 19 66</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 11, 1898</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED SECRETARY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>REAL ESTATE</b>	9. AGE (In years last birthday) <b>67</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ELMER C. STOUFFER</b>		14. MOTHER'S MAIDEN NAME <b>EURAH F. REYNOLDS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-09-7288A</b>	
17. INFIRMANT <b>HAGERSTOWN, MARYLAND</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Of Stomach</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>51X</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 1, 19 66</b> , to <b>Sept. 10, 19 66</b> , that (I) (we) last saw the deceased alive on <b>Sept. 9, 19 66</b> , and that death occurred at <b>7:45M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Edward W. Ditto, Jr.</b>		22b. DATE SIGNED <b>9/12/1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>EDWARD W. DITTO, JR. M.D.</b>		22d. ADDRESS <b>215 W. WASH. ST. HAGERSTOWN, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9/13/1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER</b>		25a. REC'D BY REGISTRAR <b>SEP 15 1966</b>	
ADDRESS <b>HAGERSTOWN, MARYLAND</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13371

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>56 yrs.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1049 Crestwood Drive</u>				d. STREET ADDRESS <u>1049 Crestwood Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Mollie</u> Middle <u>Elizabeth</u> Last <u>Stover</u>		4 DATE OF DEATH Month <u>September</u> Day <u>14</u> Year <u>1966</u>		5 SEX <u>Female</u>		6 COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 16, 1878</u>		9 AGE (n years last birthday) <u>88</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11 BIRTHPLACE (County & State, or foreign country) <u>State Line, Penna.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George Sellers</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Ellen Rummel</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-09-9843D</u>		17 INFORMANT Address <u>Hagerstown, Md.</u> <u>Mrs. Elsie Kisel 1049 Crestwood Dr.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart Disease</u> DUE TO (b) <u>Convulsed Seizures</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>3 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>Aug 21</u> , 19 <u>65</u> , to <u>9/14</u> , 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Aug 21/6</u> , 19 <u>66</u> , and that death occurred at <u>7:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>DE Martin</u>				22b. DATE SIGNED <u>9/15/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Donald E. Martin, M.D.</u>				22d. ADDRESS <u>418 N. Potomac St., Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/17/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash. Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. G. Horst</u> ADDRESS <u>Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR <u>SEP 19 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE  
HEALTH DEPT.

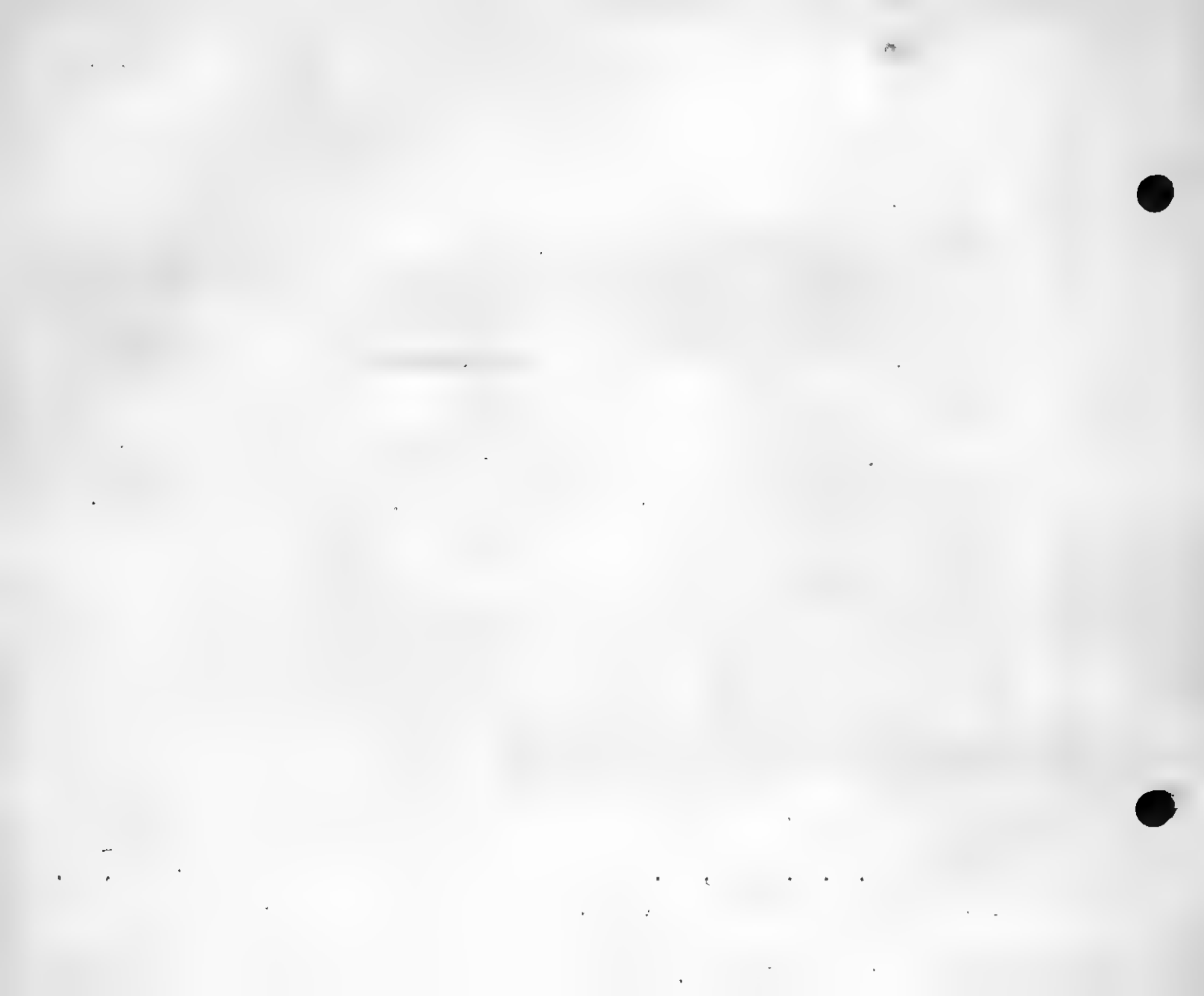
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13372

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

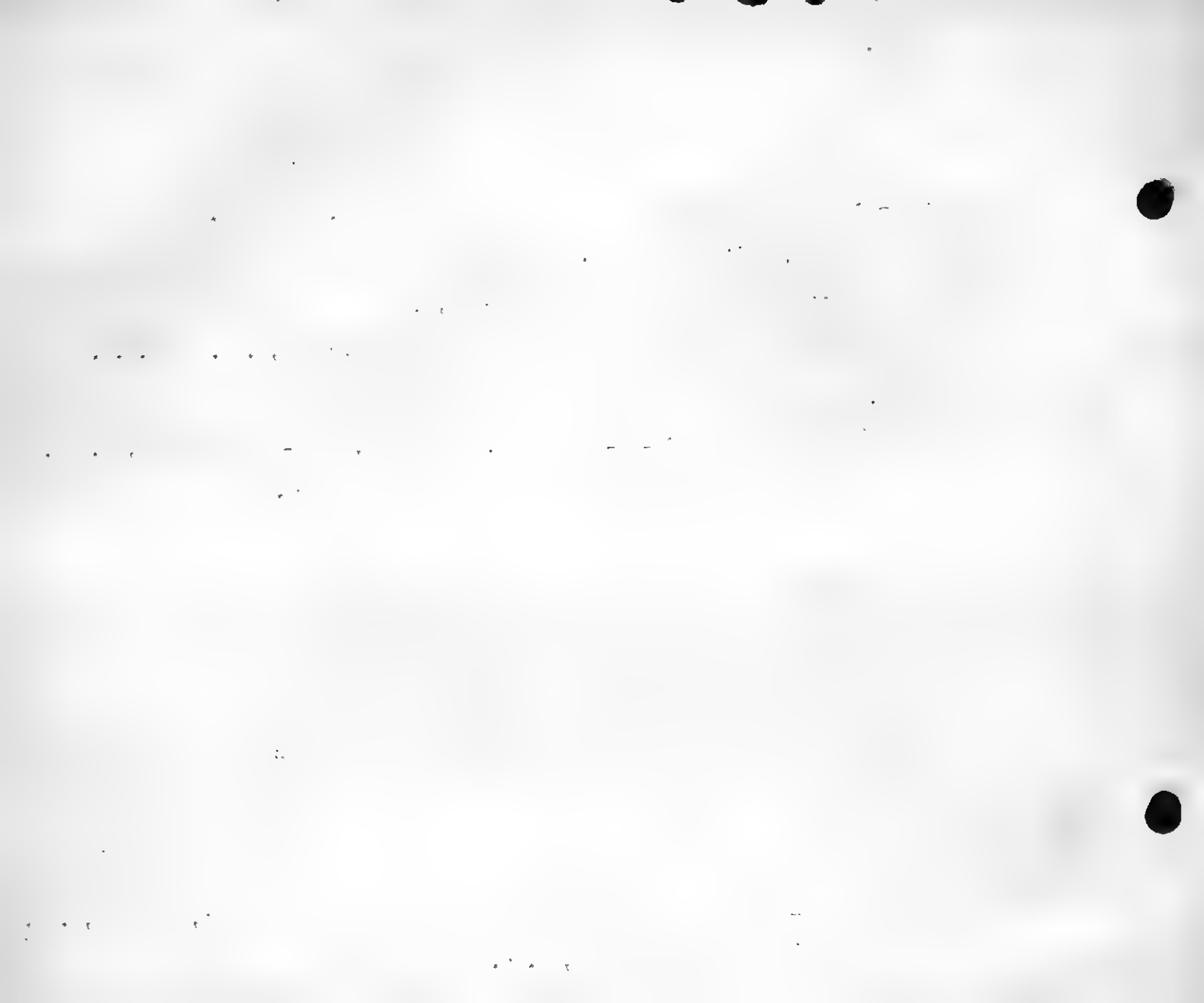
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u> c. LENGTH OF STAY IN 1b <u>29yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>134 Clarkson Ave.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Maryland</u> d. STREET ADDRESS <u>134 Clarkson Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clayton Lewis Valentine</u>		4. DATE OF DEATH Month Day Year <u>Sept 9 19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12 1910</u>
9. AGE (in years last birthday) <u>56 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>19 66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waiter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryville, Tenn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles W. Valentine</u>		14. MOTHER'S MAIDEN NAME <u>Beulah Warnner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>World War 2</u>		16. SOCIAL SECURITY NO. <u>Melvin Valentine Maryville, Tenn.</u>	
17. INFORMANT <u>Melvin Valentine Maryville, Tenn.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pulmonary Embolism, Massive</u> 466 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Probable Thrombosis Right Saphenous Vein</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED <u>9-10-66</u>		Address (Street, city, town, or county) <u>Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-13-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Knoxville, Tenn.</u>	
24. FUNERAL DIRECTOR <u>John R. Watson Jr. Hagerstown Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 14 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
29  
CERTIFICATE OF DEATH  
13373

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Boonsboro (Rural)</b> c. LENGTH OF STAY IN 1b <b>6 months</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Fahrney-Keeding Memorial Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Berkeley</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Martinsburg</b> d. STREET ADDRESS <b>814 No. Queen St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Edith</b> Middle <b>M.</b> Last <b>Vermilyea</b>		4. DATE OF DEATH Month <b>September</b> Day <b>15</b> Year <b>1966</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 2, 1892</b>	9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House duties</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Berkeley County, W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John W. Myers</b>			14. MOTHER'S MAIDEN NAME <b>Martha Brent</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>233-05-9665</b>		17. INFORMANT <b>Mrs. Charles B. Riker - Martinsburg, W. Va.,</b> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221</b> <b>Intermittent cardiac arrhythmia</b> DUE TO (b) <b>diarrhea</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 30, 1966</b> to <b>Sept 15, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 19, 1966</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.						
22a. SIGNATURE <b>G. W. L. L. L.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9/16/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>G. W. L. L. L.</b>		22d. ADDRESS <b>Boonsboro, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-17-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hedgesville Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Hedgesville, Berkeley, W. Va.</b>
24. FUNERAL DIRECTOR <b>A. K. Brown</b>		ADDRESS <b>Brown Funeral Home</b>		25a. REC'D BY REGISTRAR <b>SEP 19 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>





CERTIFICATE OF DEATH

13374

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY in lb <u>1 day</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wagnersboro</u>		d. STREET ADDRESS <u>RD #3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Co Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Howard Thomas Wacker</u>				4. DATE OF DEATH Month <u>September</u> Day <u>12</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 2, 1890</u>	
9. AGE (In years last birthday) <u>75 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Father</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Berkley Co West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>A. Hunter Wacker</u>				14. MOTHER'S MAIDEN NAME <u>Effie V. Thomas</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-16-3678</u>		17. INFORMANT <u>Mrs. Hester S. Wacker, RD #3, Wagnersboro, Pa</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>4281</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Coronary atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>Acute appendicitis--appendectomy 8-25-66. Operation 8-31-66.</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>20 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> to <u>9-12-66</u> , 19....., that (I) (we) last saw the deceased alive on <u>9-12-66</u> , 19....., and that death occurred at <u>10:30</u> from the causes and on the date stated above		22a. SIGNATURE <u>William C. Brewer, M.D.</u>					
22c. PHYSICIAN'S NAME (Type) <u>William C. Brewer, M.D.</u>		22d. ADDRESS <u>Greencastle, Pennsylvania</u>		22e. REC'D BY REGISTRAR <u>Charles Judge</u>		22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9-15-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown, Washington Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harold M. Zimmerman, Greencastle, Pa.</u>							



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20 M 1/66

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13375

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Boonsboro</b>		c. LENGTH OF STAY IN 1b <b>8 years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fahreny-Keedy Memorial Home</b>		d. STREET ADDRESS <b>120 E. Irvin Ave.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>EMMA</b> Last <b>WATKINS</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>27,</b> Year <b>19 66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 25, 1873</b>
9 AGE (In years last birthday) <b>93</b> yrs.		10 UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> M. n.	11 UNDER 24 HRS Hours <input type="checkbox"/> M. n.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. store</b>	11 BIRTHPLACE (County & State, or foreign country) <b>Huyetts Crossroad, Md.</b>
12 CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>John S. Watkins</b>		14. MOTHER'S MAIDEN NAME <b>Ann Middlekauff</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>	17. INFORMANT <b>Charles Watkins, Hagerstown, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio Vascular</b> DUE TO (b) <b>Disease</b> DUE TO (c) <b></b>			INTERVA. BETWEEN ONSET AND DEATH <b>5 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 15, 1966</b> , to <b>Sept 27, 1966</b> , that (I) (we) last saw the deceased alive on <b>Sept 27, 19 66</b> , and that death occurred at <b>9 P.</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>G W Hevan</b>		22b. DATE SIGNED <b>Sept. 29, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>G W Hevan</b>		22d. ADDRESS <b>Boonsboro, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>9-29-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>
23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>			
24 FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 3 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Judge</b>			



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**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>5 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				e. STREET ADDRESS <b>644 JEFFERSON BLVD.</b>			
3. NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>EDWARD</b> Last <b>WETZEL, III</b>				4. DATE OF DEATH Month <b>SEPT.</b> Day <b>7</b> Year <b>19 66</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 2, 1966</b>	9. AGE (in years last birthday) yrs. <b>5</b>	IF UNDER 1 YEAR Months <b>5</b>		IF UNDER 24 HRS. Hours <b>5</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>RAYMOND WETZEL, JR.</b>				14. MOTHER'S MAIDEN NAME <b>SHIRLEY BOSCH</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>RAYMOND E. WETZEL, JR. 644 JEFFERSON BLVD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Purulent Meningitis (organism not yet identified) + Diffuse Pulmonary Hemorrhage -</b> DUE TO (b) <b>Spina bifida - Myelomeningocele</b> DUE TO (c) <b>Spina bifida - Myelomeningocele</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>18 hr</b> <b>4 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9-2</b> , 19 <b>66</b> , to <b>9-7</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>9-7</b> , 19 <b>66</b> , and that death occurred at <b>5:00</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Edward W. Ditto III</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>9/7/1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>EDWARD W. DITTO III M.D.</b>				22d. ADDRESS <b>217 W. WASH. ST. HAGERSTOWN, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>SEPT. 8, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER HAGERSTOWN, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>SEP 13 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



## CERTIFICATE OF DEATH

13377

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>79 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>124 W. Howard St.</b>		d. STREET ADDRESS <b>124 W. Howard St.</b>	
3 NAME OF DECEASED (Type or print) <b>JOHN LUTHER WIEBEL, SR.</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>3</b> Year <b>1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 19, 1887</b>
9 AGE (In years last birthday) yrs <b>79</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Weaver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ribbon mfg.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Augustus Wiebel</b>		14. MOTHER'S MAIDEN NAME <b>Maryetta Jones</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Edward Wiebel, Sr.</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) <b>Arterio-sclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Myocardium</b>			INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 19, 1966</b> to <b>Sept 3, 1966</b> that (I) (we) last saw the deceased alive on <b>Sept 3, 1966</b> , and that death occurred at <b>8 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Sidney Novenstein</b>		22b. DATE SIGNED <b>9-3-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>SIDNEY NOVENSTEIN</b>		22d. ADDRESS <b>FUNKSTOWN MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>9/6/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR <b>MINNICH FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>SEP 13 1966</b>	
ADDRESS <b>Hagerstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>3 weeks</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport RFD #1</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>					d. STREET ADDRESS <u>Cedar Grove</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jerry</u> Middle <u>Elias</u> Last <u>Young</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>18</u> Year <u>1966</u>						
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 13 1886</u>		9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>4</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tannery</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>Jerry Young Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Thomas</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219 01 7393</u>		17. INFORMANT <u>Mrs. Sophia Young</u>		Address <u>Williamsport Md. RFD #1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>2044</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>leukemia, chronic and nephrosclerosis</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition and dehydration</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2-3 weeks</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1961</u> to <u>Sept. 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept. 18 1966</u> and that death occurred at <u>A M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Howard N. Weeks, M.D.</u>				22b. DATE SIGNED <u>9/19/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M.D.</u>				22d. ADDRESS <u>580 Northern Avenue Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 21-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Williamsport Md.</u>			
24. FUNERAL DIRECTOR <u>Mr. Albert L. Leaf Williamsport Md.</u>				25a. REC'D BY REGISTRAR <u>SEP 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

5551

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
13385  
13379  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>10 hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Earl</b> Middle <b>Theodore</b> Last <b>Zimmerman</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>18</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 22 1894</b>
9. AGE (In years last birthday) <b>71 yrs.</b>		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>26</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hagerstown Water Plant</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Cletus Zimmerman</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Trumpower</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220 09 9221AA</b>	
17. INFORMANT <b>Mrs. Harry Rupp Williamsport, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration of gastric material</b> 5711 DUE TO <b>Gastrointestinal hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Acute gastroenteritis - cause</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Emphysema; Bronchitis; Arteriosclerotic C.V.II.</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town) (County) (State)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>16 Jan. 1958</b> , to <b>late</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>17 Sep 1966</b> , and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above.		22. SIGNATURE <b>Richard T. Binford</b>	
22a. PHYSICIAN'S NAME (Type) <b>RICHARD T. BINFORD, M. D.</b>		22b. DATE SIGNED <b>SEP 21 1966</b>	
22c. ADDRESS <b>135 POTOMAC AVENUE HAGERSTOWN, MD.</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 20-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Williamsport Md.</b>	
24. FUNERAL DIRECTOR <b>Albert L. Leaf Williamsport Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 21 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S SIGNATURE	

TO THE PRESIDENT OF THE UNIVERSITY OF CHICAGO  
FROM THE FACULTY OF THE DIVISION OF THE PHYSICAL SCIENCES  
RESOLUTION  
The Faculty of the Division of the Physical Sciences  
of the University of Chicago, in session at the  
annual meeting of the Division, held at the  
University of Chicago, Chicago, Illinois, on  
the 10th day of May, 1911, do hereby  
resolve that the following resolution be  
adopted:

Resolved, That the Faculty of the Division of the Physical Sciences  
of the University of Chicago, in session at the  
annual meeting of the Division, held at the  
University of Chicago, Chicago, Illinois, on  
the 10th day of May, 1911, do hereby  
resolve that the following resolution be  
adopted:

Resolved, That the Faculty of the Division of the Physical Sciences  
of the University of Chicago, in session at the  
annual meeting of the Division, held at the  
University of Chicago, Chicago, Illinois, on  
the 10th day of May, 1911, do hereby  
resolve that the following resolution be  
adopted: